

HRH Technical Report # 2

HRH: A POLITICAL ECONOMY AND INSTITUTIONAL ANALYSIS OF THE INDIAN CONTEXT

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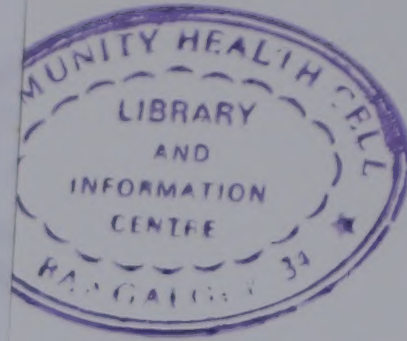
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Executive Summary

There is a paradox of India being among the pioneers in health service planning that has consistently over the years prioritized the importance of human resources in it and the broader perception that government has mostly neglected public health as a whole. This paradox may at least partially be understood as resulting from a weak implementation of policy plans. The major policy thrusts concerning HRH in the country have been significantly shaped at the national level through formal consultative processes that include key stakeholders and participants from states. Part I of this paper reviews the federal political context and the influence of key stakeholders at the national level on HRH policy. The implementation of policy is usually shaped at a different level and most often entrusted to officials at the state or local levels. Part II of the paper maps organizations to key HRH functions in the Central Health Service (CHS) and the state health systems of Uttar Pradesh and Tamil Nadu. In spite of significant similarities in the institutional contexts of the three cases, the paper illustrates through analysis of the doctor recruitment process how differences between them influence the effectiveness of recent recruitment drives. In Part III of this paper, evidence further gathered from the three selected cases reveal how institutional factors can affect the implementation of HRH policies. The evidence from the cases suggest that in the implementation of policy more immediate institutional problems are faced that have so far received largely insufficient attention in the national policy and plans. With the states expected to formulate state-specific plans for HRH under NRHM, there is currently a unique opportunity to address context-specific weak institutional processes and design policies to reflect more realistic assessments of what institutions can deliver. Evidence drawn from the cases also highlight the influence of stakeholder interests and why more strategic management of context-specific stakeholder demands can succeed in aligning HRH policy implementation more effectively with public goals.

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Introduction

India is one of the pioneers in health service planning and in recognizing human resources as key to a well-functioning health system. The first independent government of India had no less than three significant reports on health policy planning even before it initiated the first of its Five-Year Plans.¹ Ever since, each subsequent Plan until the current eleventh one, has strived with all good-intention to strategize on elements of human resource development for better health care provision.

There is no doubt that significant improvements in health have been achieved since independence, as reflected in the lowering of infant mortality and a steady increase in life expectancy. Nevertheless, public health has been “one of the most neglected aspects” of government policies for furthering development in the country (Dreze and Sen, 2002). The weak implementation of these policy plans may at least partially explain this paradox. This paper aims to analyze HRH policy content in these national plans and the experience of HRH policy implementation in three selected cases through an analysis of the institutional context and influence of key stakeholder interests.

Structure of the Paper

This paper is organized into four parts. Part I of this paper reviews the federal political context and the influence of key stakeholders at the national level on HRH policy. It also undertakes a historical review of HRH policy content in the Five-Year plans and key government reports that influenced health policy and planning.

Part II and Part III draw on empirical data from three selected cases: (i) the Central Health Service (CHS) managed by the central health ministry; (ii) the Uttar Pradesh (UP) government health system; and (iii) Tamil Nadu government health system. Part II of the paper draws on recent health systems diagnostic studies in providing a framework to map organizations to core HRH functions. This framework is applied to the three selected cases for the core HR functions pertaining to the doctor and nursing cadres. As an illustrative example, a single core HR function concerning doctor recruitment is further investigated in all three cases to demonstrate how current institutional context influences the effectiveness of recent recruitment drives. In Part III of this paper, evidence further gathered from the three selected cases reveal how institutional factors can affect the implementation of HRH policies.

In Part IV, the conclusions that can be drawn from the evidence in the paper is discussed. The evidence from the cases suggest that in the implementation of policy more immediate institutional problems are faced that have so far received largely insufficient attention in the national policy and plans. Evidence drawn from the cases also highlight the influence of stakeholder interests and why more strategic management of context-specific stakeholder demands can succeed in aligning HRH policy implementation more effectively with public goals in policy plans.

¹ Reports of the Bhore Committee (1942-46), the Chopra Committee (1946) and the Sokhey Committee (1948)

Analytical Approach: A Political Economy and Institutional perspective²

The recent literature on the political economy of health brings to light the significance of the concepts of 'power' and 'process' to health policy implementation (Walt, 1994). It highlights the important role that powerful domestic interest groups can play to the success, failure, or partial implementation of health policy or reform measures, even to the extent of legitimizing or destabilizing the political regime (Reich, 1994, 2002; Bossert et al, 1998; Glassman et al, 1999). The emphasis is on individual or collective actors and their power to influence. The broader context in which the actors and institutions are embedded is equally important. Context is affected by many factors such as by the nature of political regime, by the legitimating 'authority-claims' of the particular ruling government and by historical experience and culture; none of these factors are directly health-related but of potential significance to policy agenda-setting.³ In Part I, HRH policy making in the broader Indian national context is the focus.

In addition, the analysis in this paper highlights the institutional role in undertaking the implementation process, especially in Part II and III. The importance of the institutional context to political authority and policy implementation has been detailed persuasively elsewhere that precludes the need for a fresh reaffirmation here.⁴ The approach of such research is usually a narrative account that provides a detailed description of the case study, which forms the focus of the analysis. This paper collects evidence from three selected cases to analyze further the institutional factors affecting HRH policy implementation.

Part I

HRH Policy in the National Context

HRH Policy in the federal context

According to the Indian constitution, health service is considered a State subject and therefore, in theory, states are responsible for developing and maintaining their own health services. The Centre is allocated responsibility only for institutions deemed of national importance in medical education and research. On the Concurrent List are the following health-related functions: preventing the spread of infectious diseases, medical education, regulation of the medical profession and drugs, population control, mental health and vital statistics.

² This short section is based on an extensive review of the literature on institutional analysis, policy analysis and stakeholder analysis. However, it remains deliberately summarised to retain 'the flow' and prevent a long digression away from the Indian context to a theoretical domain.

³ Policy agenda-setting has been discussed and used with empirical cases in Kingdon (1984) and Shiffman (2007)

⁴ See, for instance, Herbst (1990), Haggard and Webb (1993) as samples of such analysis.

The existing constitutional division of responsibilities in the health sector are the remnants of reforms introduced under British Rule through Government Acts in 1935 and earlier still in 1919. The reforms initially introduced the concept of 'dyarchy' to India which devolved specified functional responsibilities to the states that were not considered a core priority concern to the central government in Delhi and to imperial interests; the subjects of public health and sanitation, in this early prioritization of concerns, were deemed the responsibility of states. The health of the army, however, remained a core priority for British Rule and the Indian Medical Service (IMS), which existed to principally serve this very interest, remained an All-India service. The first independent Indian government at the centre abolished the IMS as having been a colonial structure built to serve limited interests and not people at large. The constitutional sharing of powers that existed through the 1935 Act was, however, retained with health and sanitation principally a responsibility of states. Simultaneously, the first independent central government also endorsed the recommendation of the Bhore Committee that visualized a National Health Service, funded and delivered entirely by a government-based system. However, the Bhore Report called for a level of public commitment by the governments (Centre or states) that, at the time, was not feasible for any policy-area at all, let alone one of relatively low priority such as health. For as one speaker in the constituent assembly debates highlighted, the 300 crore rupees calculated by the Bhore Report needed for the health sector was the "*total* of the provincial and central taxation" (cited in Amrith, 2007).

This brief history highlights two important facts: First, even though the Bhore Committee and national policy discourse gave importance to health service for the poor, the actual construction and monitoring of the growth of primary healthcare infrastructure was left entirely up to states. Second, with the abolition of an IMS-like structure, the central government no longer controlled or had the direct allegiance of a cadre of doctors working in the states. Instead, the Centre became largely reliant on its financial provisions to states to supplement their health-related expenditure to influence states' health policies. Understanding relative roles and shares in government financing of health expenditure between the Centre and states is important. The Centre's financing of health expenditure is in part a *tool* for the central government to influence health policy direction in the states.

In the first two Plans, the Centre's principal expenditure towards health was on the communicable diseases programs. In the 1950s and 1960s, the entire focus of centrally financed programs in India was to manage epidemics (Jeffrey, 1988; Duggal, 2005; Amrith, 2007). The remarkable initial achievement of the malaria program and use of extensive trained personnel is a case in point. This single program employed as many as 1,50,000 people by 1961. The expenditure of the state governments was largely on the urban health infrastructure and on tertiary medical care. Consequently, a separation of functional responsibilities in the health system came about with the Centre (through the Planning Commission) investing in preventive and promotive programs, while the states largely focused their attention on curative care. Moreover, there was little focus of the state governments on strengthening the infrastructure for a primary healthcare system, even though reports at the Centre (from Bhore to Mudaliar) kept this at the centre of health policy discourse. The weakness of the primary health care system ironically undermined what the Centre set out to achieve through the central disease programs. These programs aimed at coverage, but this was not supported by a primary health system

that provided promotive and curative services to patients. The Centre approached rural infrastructure, therefore, from the perspective of communicable disease and population programs that stressed the need for functional PHCs to consolidate the maintenance phase of these programs.⁵

A persistent overlap in the roles of Centre and states also remains. On the one hand, this allows for some flexibility, but on the other hand there is some confusion on functions; a general observation in both the 1983 and 2002 National Health Policy documents. One such instance is in the regulatory role that national bodies and state-level councils together play over medical and nursing educational institutes.

⁵ An explanation may be found in the dramatic reversal of the malaria programme in the mid-1960s. The Fourth Plan acknowledged the spurt in the incidence of malaria from 100,000 cases annually between 1963 and 1965, to 149,102 cases. Reversions of increased malaria cases did not occur in states where the rural health services were well developed, such as Mysore and Kerala.

Box 1:**Proposal for an Indian Medical & Health Service (IMHS) and its several failed attempts**

The most recent demand for an IMHS is found in the NCMH Report (2005). It can, however, also be traced to all the reports of the following government committees: Mudaliar (1961), Jungalwalla (1967), Tikku (1991), Bajaj (1996) and the Fifth Pay Commission (1997).

One reason for demanding the IMHS stems from the current institutional weaknesses of the Directorate General of Health Services of the country, which also serves as the headquarters organization of the Central Health Service. CHS doctors, who typically have little experience working in rural areas, occupy all senior technical/managerial posts. Consequently, many have little familiarity with the problems that state governments face at the time of implementation. Those in support of the IMHS argue that it will facilitate bridging this gap, encourage better professional communication and understanding between the Centre and states, and result in improvement in *technical leadership and management*. In contrast, states have argued that the proposal for an IMHS is a means through which the Centre attempts to control a cadre of doctors working in the states, like the Colonial Government did through the Indian Medical Service (IMS).

The idea of having the all-India Service was first stressed by the States Reorganisation Commission in their 1955 Report to the central government. Endorsed in 1961, the *Rajya Sabha* passed the requisite resolution to set up the new all-India Services. In 1963, a draft memorandum and drafts of the rules governing the proposed IMHS were drawn up and shared with the states. The Government of Tamil Nadu stated that any step in the direction of diminishing the autonomy of the State was likely to be objected to and that the IMHS threatened precisely this. Opposition stemmed also from the states of Kerala and Karnataka on grounds that the IMHS was an encroachment on provincial autonomy. In May 1968, the central government reconsidered the matter and decided to go ahead to constitute the all-India service, excluding these states. The finalized Service Rules of this new proposed cadre under CHS was tabled in both Houses of Parliament in February 1969 for formal notification to creating an all-India Service. At this point, the state governments of Punjab, West Bengal, Maharashtra and Assam also expressed their unwillingness to participate in the scheme.

The Centre continued to pursue the matter. In August 1972, the then Minister of Health and Family Planning informed that the Centre would proceed with the formulation of the service even if some states stayed out. The Estimates Committee of the *Lok Sabha* also supported the formation of an all-India Medical and Health Service in 1976. States' response remained weak and not encouraging. The Department of Personnel and Administrative Reforms nevertheless took the view that constitution of the service should be notified and the details could be worked out later. Accordingly, the Centre issued the notification for the IMHS in January 1977. A new central government, the following year, however chose not to go ahead with the creation of the IMHS in light of the opposition from the states. The Centre still revived the IMHS proposal three years later and once again in 1986. Out of the 25 states then existing, only seven states were in support of an IMHS with the remaining either having not expressed a view or openly in opposition to such a service. While there was no legal impediment in constituting an all-India service in which only some states participated, by then there were weighty political reasons against following such a course of action.

‘Voice’ of different types of health providers in influencing policy

The extent of ‘voice’ (Hirschman, 1970) that members of a group have in any system conveys the extent to which these members can express their dissatisfaction and interests to the prevailing authority – here, the government – to influence policy. In the health system, as in many such large systems, members of a group can most effectively articulate their position through collective action lobbying (Olson, 1982). In the Indian health system, both at the Centre and states, the interests of doctors employed in the government service have, in the past, been the most influential – the ‘In-Group’, so to say. In relation to past health policy, other significant numbers of the health workforce such as private practitioners, practitioners of traditional Indian medicine and Homeopathy, as well as nurses have, in contrast, been the ‘Out-Groups’. This section reviews the engagement of the policy process with these different groups of health personnel.

Doctors’ Voice in the Government System:

Public health policy in the early decades of India must be contextualized in the modernist enterprise of state – the aim of the state to transform society and economy drawing on the most advanced models and scientific approach available. As one historical analysis of health policy at the central level notes, the doctor syndrome loomed large in the minds of the planners, with actual policy revolving around conditions and prospects of doctors over and above all other health personnel (Duggal, 2005). Another review of government health policy observes that although major health policy documents since 1947 have all stressed the need for more numbers of auxiliary personnel than doctors, the problems of training more doctors have always been discussed first (Jeffrey, 1988). The Bhore Report (1946) endorsed a policy where the government focused its limited resources in training only one kind of doctor – ‘the highly trained type of physician’ – that the Report termed the ‘basic doctor’. Consequently the first several Five-Year Plans allocated and oversaw the growth of medical colleges and significant expansion in admissions geared towards a single type of medical degree, the MBBS. This degree came to hold a stature of social exclusivity, promoted for several decades by the state and guarded against intrusion of any ‘lesser qualified’ medical practitioners by the main doctors’ professional association, the Indian Medical Association (IMA) and the Medical Council of India (MCI). For the first couple of decades post-1947, the central government promoted an exclusive western training for the country’s medical doctors in a deliberate move to draw international legitimacy to the medical system and to ensure that Indian doctors were trained to internationally acceptable ‘modern’ standards. The MCI, consequently, is only concerned with the registration of doctors trained in western medicine.

The draft National Education Policy in Health Sciences (1989) ruefully notes: ‘There has been far less concern, *almost amounting to negligence*, for the planning and production of allied health professionals and other categories of health care providers, as compared to that for medical manpower. The primary reason for this being *the medical bias in the entire process of health system planning and health manpower development (italics added).*’

The powerful influence of the medical doctor fraternity has been perhaps most apparent in guarding their exclusivity as the 'highly trained physician' of the health system. To address the problem of insufficient doctors for rural areas, the 3rd (1960-65) Plan proposed "that a new short term course for the training of medical assistants should be instituted and after these assistants had worked for five years at a PHC, they could complete their education to become full fledged doctors and continue in public service". The Medical Council and the doctors lobby within government opposed this and the idea was politely shelved.

Other Voices:

Private Practitioners

The Indian Medical Association (IMA) has historically been identified with the interests of private practitioners, which means that they have had less influence on policy than doctor-administrators within the public sector. Yet, in spite of a very limited spread of member-doctors from rural areas, the IMA nevertheless has been more successful than organizations of any other type of practitioners, whether they have been paramedical practitioners or from other systems of medicine.

The collective articulation of the voice of private practitioners, other than the IMA and its state-level branches, has been less clear. Part of the reason is that private health care has been so far principally through independent practitioners, who remains largely outside of the purview of the policies of the government health system and programs. Rohde and Vishwanathan (1995) identified the 'rural private practitioners' as largely comprising providers who were not legally qualified doctors of any system. Some of these providers were remnants of government policy that legally promoted 'less than fully qualified doctors' (Berman, 1998) as 'registered medical practitioners (RMPs)' or 'licensed medical practitioners (LMPs)' until the mid-1970s in many states.

Over one-third of the private practitioners have no registration of any kind and 25% are AYUSH practitioners (NCMH, 2005). Most characterizations of the private sector consist largely of sole practitioners or small nursing homes having 1-20 beds, serving the urban and semi-urban clientele and focused on curative care. There is very little documentation on the impact this group has had on policy through collective action. Those private practitioners that exist outside of government registration do not engage at all with government HRH policies. At present, there is no uniform nationwide system of registering either practitioners or institutions providing health care in the private/voluntary sectors; nor is there a mechanism for obtaining and analyzing information on health care infrastructure and manpower in these sectors at the district level. This is a notable omission since the private sector currently occupies centre-stage. It is likely that even in the 1950s and 1960s government was not the principal provider of ambulatory care services. The omission is more significant today when 68 per cent of the 15,393 hospitals (cited by Ministry of Health & Family Welfare), 37 per cent of the hospital/clinic based beds are contributed by the private

sector⁶ and over 80 per cent of the provisioning of ambulatory health care is attributed to the private sector.

AYUSH practitioners

The dominant medical discourse projects practitioners of *Ayurveda, Yoga, Unani, Siddha and Homeopathy* (AYUSH) as the 'unscientific other' and assigns all of them a peripheral, residual role in the overall health care system (Abraham, 2005). The state-financed institutional development of Indian Systems of Medicine (ISM) and Homeopathy in independent India really took off only in the 1970s and 1980s when institutions structured similar to those in allopathy were established in ayurveda and homeopathy. A separate department in the ministry was only created in 1995, in response to a long pending demand and an entire separate Ministry of AYUSH formed in 2003. The only other significant institutions are all involved with research or the regulation of research: In 1959, the Central Council of Ayurvedic Research was set up to advise the central government on the formulation of a coordinated policy for research in Ayurveda. Two advisory committees, one on Homoeopathy and the other on Unani, were also created. In 1960, a Panel set up by the Planning Commission recommended establishing a Central Council of Indian Medicine for regulating the standards of medicines. Over a decade later, in 1973, the CCIM finally came into existence. Of the professional associations of AYUSH, the most prominent is the Ayurvedic Congress. However, despite being in its centenary year of existence, its role, like that of the other AYUSH associations has been marginal to health policy planning.

Although the government discourse now emphasizes a need to 'mainstream AYUSH' with allopathic medicine, evidence of the past fault line continues. It is most evident in the issue of regulating physicians trained in AYUSH and their practicing of modern medicine. The Indian Medical Association (IMA) and its state-level branches have been rallying, so far successfully, against this privilege. Supreme Court rulings in two separate cases in 1996 and 1998 favored the IMA's stand. In spite of current laws not favorable to the practice of allopathic medicine by the AYUSH practitioners, it is equally clear that such 'illegal' practice is largely the norm in rural areas.

India has a vast network of governmental and private AYUSH institutions. There are 458 AYUSH colleges with an admission capacity of 23,555, 98 colleges with post graduation facilities, 3,100 hospitals with over 65,000 beds, 22,300 dispensaries, and 6,95,024 registered practitioners. The foremost problems these institutions face are lack of essential staff, infrastructure, diagnostic facilities and drugs in the existing health care network of AYUSH. The other important failure cited in these institutions is inadequacies in quality of training of practitioners. Their noninvolvement in the national health and family welfare programs has meant that there has been neglect on the part of government toward these institutions in the past. Treatment meted out to the institutions and manpower of these systems is not at par with that being given to the allopathic system. The most recent working group called by the Planning Commission for drafting the 11th Plan on 'Access to Health Systems and AYUSH' retains a distinct distance between the allopathic system and the AYUSH practitioner, even while advocating the 'coexistence' of both systems. The policy of

⁶ Planning Commission, X Plan Mid-Term Review

'mainstreaming AYUSH' to the government allopathic system toes a fine line of functional integration without compromising the 'ethical purity' of either system, and warning against an attempt to "try and produce a hybrid doctor". The government, in bringing the AYUSH practitioner within the institutional walls of a PHC and CHC, advocates "a cafeteria approach of making AYUSH and Allopathic systems available under one roof" for facilitating patient choice and "cross-system referrals".⁷

Nurses

The 8th (1992-1997) Plan observed that "while the States have been more than anxious to start new medical colleges, their efforts to develop institutions for training of paramedical staff have been entirely suboptimal". It further noted that while, ideally, the doctor- nurse ratio should be 1:3, in 1992 there were less than 3,00,000 registered nurses against 4,00,000 registered medical graduates.

It is remarkable that after a 1954 Committee that addressed the employment conditions of the nursing profession, there was no subsequent review of all aspects of the nursing component of health services until 1989, when a so-called High Power Committee of the government on nursing reported on its findings. Unlike in other countries, nursing personnel are not actively involved in policy formulation in India, even on matters that affect nursing practice. In a recent note on nursing for the National Commission on the Macroeconomics of Health, the nursing advisor at the central government and the senior-most representative of the profession in policy for over a decade laments: "There are an inadequate number of nurse and midwife leaders at the national and State levels for nursing practice, research, education, management, planning and policy development. Although the nurse is a member of the health team, she/he is never asked to represent the profession in planning and policy formulation for nursing services, education, etc." As the 1989 Report succinctly observes, following its extensive field visits and interviews, "the nurses are given the role of simply following the instructions" and "are hardly involved in any decision making process".

The Trained Nurses' Association of India (TNAI), founded in 1922 prior to even the Medical Council, has its own branches (unlike the Medical Council) in almost all states representing all forms of nursing, including ANMs. It has, however, had very limited success in its advocacy with state governments. For instance, the TNAI has been a strong advocate of the 1989 Report's recommendation that nurses speak for the cadre in a reformed organization for management of nursing at the state directorates, but state governments (with the exception of West Bengal) have made little reform and doctors everywhere remain the principal spokesmen in policy matters for the nursing profession. Indeed, even considering that recommendations of government-commissioned committees have had a mixed record of being translated into policy, the recommendations of the 1989 Committee Report on nursing stand out for how very few of its recommendations have been acted upon by both the Central and State governments. At the state-level, however, unions of nurses tend to have a greater influence on policy through agitation than the formal nurses' associations do through officially channeled advocacy.

⁷ Planning Commission, Eleventh Plan Working Group Report on 'Access to Health Systems including AYUSH' (2006)

Central and State roles in financing of HRH-related expenditures⁸

The main focus of expenditures of the central government has been on various centrally-sponsored disease control and population control programs. These are funded primarily by the central government as part of the Plan-budget but implemented by the states.⁹ At the Centre, Plan-based expenditures on Health greatly exceed those of Non-Plan expenditure with a ratio most recently of approximately 10:1. Since 2005, the more prominent of these programs, except for the National AIDS Control Program, have been subsumed under the National Rural Health Mission (NRHM). The increased outlays by the Central government under NRHM have meant that the historically already high ratio of Plan to Non-Plan spending on Health at the Centre has further increased within the last few years.

Unlike at the Centre, the states' Non-Plan component of the budget is significantly larger than the Plan component. This is principally because the salaries of much of the staff, which constitutes 70-80% of the state health budget, come under the Non-Plan heading.¹⁰ State budgets are burdened with this significant share of recurrent non-Plan expenditure on salaries that is largely inflexible. Aside from such significant non-Plan expenditure, states are also expected to provide a share of the funds allocated to many centrally-sponsored national programs as Plan expenditures.¹¹ The major share of inflexible recurrent non-Plan expenditure and the obligation to contribute to centrally-sponsored schemes have determined largely the entire budgetary allocations towards health of poorer states with little additional resources. In this past structural context of Centre and State roles in health financing, the Centre's financing of health expenditure has therefore functioned as a *tool* for the central government to influence health policy direction in especially the poorer states.

NRHM was launched within this context in 2005 and envisages a shift in the relationship between the Central and state government with regards to Health as a subject. While the Central government aims to increase its share in the financing of health care from the current 20% to 40%, the states are to have much more control over the expenditure of these funds. Previously, the central government would give funding to the states for national health programs under defined budget heads and, therefore, there was little flexibility, as noted above, in how this money could be utilized. However, with several of these programs subsumed under the NRHM and an

⁸ This section is based on information from various sources: Finance Commission (2004), Rao and Singh (2005), Duggal in CEHAT(2005), Berman and Ahuja (unpublished, 2008) and Five-Year Plans

⁹ Both at the Centre and states the budget is divided into Plan and Non-Plan expenditures. Plan expenditures generally include spending on new schemes and upgradation or expansion of continuing schemes as well as outlays on new or replacement infrastructure. In contrast, Non-Plan expenditures cover recurrent expenditures (such as on salaries) as well as expenditures on the operation and maintenance of completed schemes (previously once in 'Plan') and already existing institutions. The distinction appears to be somewhat artificial and is also quite flexible; even though guidelines exist, it is up to individual state governments to divide their spending into Plan and Non-Plan (Finance Commission, 2004).

¹⁰ An important exception are salaries of ANMs paid for almost-wholly (98.4%) by the centrally funded Family Welfare program and of staff for specific disease control programs paid for from grants for the particular program.

¹¹ The contribution of states towards centrally-sponsored programs can vary considerably. Whereas the Malaria Program used to be on a 50:50 cost-sharing basis between the Centre and the states, the National AIDS Control Program is funded entirely by the central government.

emphasis laid on decentralization of HRH policy formulation, states are expected to play a greater role in the allocation and expenditure of funds from the Centre.

In an MoU the states have signed with the central Ministry of Health and Family welfare (MOHFW) under NRHM, the former commit themselves to outlining a State Project Implementation Plan (PIP) reflecting all sources of funding for the health sector, a convergence plan for NRHM and proposals for institutional reform. The States' PIPs need to be approved by the Empowered Programme Committee (EPC) in MOHFW and implementation of the plans is to be periodically reviewed by the Ministry. Moreover, the state governments agree to certain performance indicators and release of *grants-in-aid* is subject to satisfactory progress on these indicators. The performance indicators range from vacancy rates in various staff posts, to institutional reforms and targets for each of the disease control programs.

The major policy change is that the states are now to select from a menu of policy options that NRHM provides the policies most suitable for how NRHM (central) funds are spent. Since there is a NRHM Mission Document and Framework of Implementation report, the Centre does continue its influence through the larger HRH policy goals that NRHM promotes but permits the states flexibility to adopt state-specific policy priorities.

A Brief Review of HRH-related Policies at National Level¹²

As this paper noted at the very beginning, there has been no dearth of grand strategizing through Plans and government-sponsored committee reports that highlight the issues pertaining to human resources for health which need prioritization in order to deliver better health care services to the people, especially the rural poor.

The 'Framework for Implementation' report of NRHM launched in 2005 is, from this lens, the most recent such policy document, or grand strategy plan. Its overarching goal is to "improve the availability of, and access to, quality health care by people, especially for those residing in rural areas, the poor, women and children" (NRHM Mission Document). Its more specific objectives include reducing the Maternal Mortality Ratio (MMR) in the country from 407 to 100 per 1,00,000 live births, Infant Mortality Ratio (IMR) from 60 to 30 per 1000 live births and the Total Fertility Rate (TFR) from 3.0 to 2.1 by the projected conclusion of the mission in 2012. The NRHM Mission Document and the Framework for Implementation both outline in detail the strategies to be adopted to achieve these goals. These include what is referred to as an "architectural correction of the health system" for better use of funds and improved service delivery. Other broad ideas espoused by NRHM include decentralization and community participation, improvement of infrastructure, horizontal integration of vertical Health and Family Welfare Programs and transparent policies for Human Resources in Health. The Mission Document also mentions, amongst its supplementary strategies, the promotion of public-private partnerships, the mainstreaming of AYUSH and the re-orientation of medical education towards rural health issues. Many of these policies are inspired by ideas conceived of at an earlier time and a historical review of these previous recommendations for reform provides context for the current approach articulated under NRHM.

Indeed, there are certain NRHM policy recommendations that have been expressed repeatedly over time by a majority of the committee reports and five-year plan documents. There is equally the case of a policy recommendation that features prominently at one time in a committee report and a five-year plan but which is shelved or reversed in a subsequent plan/report only to return later once again as a notable policy decision of a different government health plan. Understanding the reason for such a cyclical past to a particular policy can contextualize the policy in an existing debate and indicate which perspective was more dominant in government and internationally at the time. This section reviews *both of these types of recurrent policy recommendations* relating to human resources for health separately. That these policies are recurrent draws our attention to *why* implementation has been inadequate and the significance of institutions as implementation agents (Part II and III of this paper).

¹² This section and all quotes in it draw directly from a reading of Five-Year Plans and Reports cited. There is a less detailed overview of HRH policies in WHO, 2007.

Repetitive and longstanding HRH Policies:

The absence of adequate number of doctors in rural areas has plagued the government health system and policy makers at the Centre have grappled with different options on how to address the problem for over three decades.

Currently, NRHM recommends *adapting the medical education curriculum and making it more pertinent towards rural health*. Beginning with the Bhore Committee in 1943, this focus on public health has been repeatedly revisited in the form of proposals to increase and strengthen Departments of Preventive and Social Medicine (PSM) in medical colleges. Furthermore, in 1975, on the recommendation of the Study Group on Medical Education and Support Manpower (Shrivastava Committee), the Reorienting of Medical Education (ROME) program was initiated. Since then, the 6th (1980-85), 7th (1985-89) and 8th (1992-1997) Plans, including the National Health Policy of 1983, have all recognized the need to orient medical education towards community health. Similarly, in keeping with this rural focus, there have also been repeated proposals for mandatory rural service for doctors. At times these were to be part of the internship, at others it was deemed that it should be a compulsory component of government service. Some reports propose incentives, such as preferences for those who have served in rural areas in post-graduate degrees and offers of faster promotions. NRHM draws on both these strategies, advocating compulsory rural service as well as incentives for those working in difficult areas.

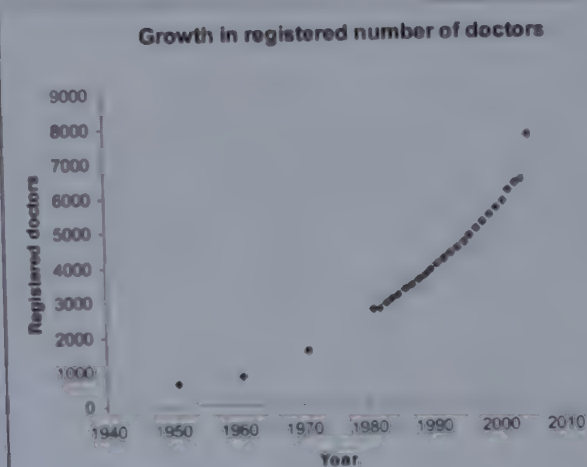
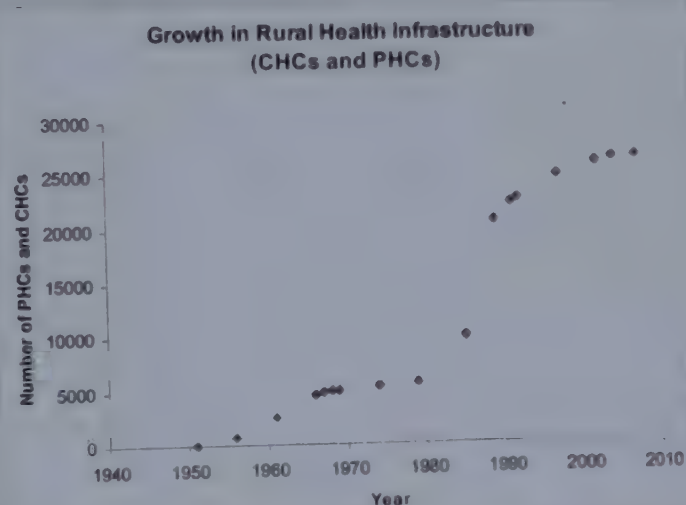
Another common theme throughout the years has been the *need to integrate AYUSH systems* into the public health system. To begin with, there was an emphasis on research into traditional systems of medicine and towards the regulation of training. The trend in recent years, however, is to expand the role of AYUSH to address some of the deficiencies of the public health system. For example the 7th (1985-1989) Plan and the Bajaj Committee (1987) both recommend training AYUSH practitioners for strengthening the national disease control programs. Building on this trend, NRHM recommends having AYUSH doctors at PHCs and CHCs to complement the allopathic public health system.

The Medical Education Review Committee (1983) recommended the establishment of a central coordinating agency for planning, organizing and monitoring *continuing education programmes* all over the country. This has remained on the agenda of every Plan since. For instance, the 9th (1997-2002) Plan set out to 'ensure continuing knowledge and skill upgradation of all health care providers through Continuing Education Programmes with emphasis on multi-professional problem solving learning strategies', even though the previously proposed central coordinating agency had never been established in the interim.

The *training of paramedical human resources* has also been a frequent objective in policy documents over the past six decades. Training of nurses, midwives, ANMs and health visitors was particularly emphasized although pharmacists, sanitary inspectors, medical assistants, hospital workers and public health engineers were also mentioned. NRHM also promotes increased training of paramedical staff and takes it one step further by also emphasizing skill upgradation and multi-skilling of existing medical and paramedical workers.

Primary health care infrastructure finds mention in all Plans. However, the Mudaliar Committee (1961) acknowledged that, in reality, primary health care infrastructure was not given the importance it was ascribed in the Bhore Report right from the start. Gains from the central government's focus on the communicable disease programmes, it was argued, was less sustainable in light of the absence of support from non-existing or non-functional primary health centres. The government's priority, however, has subsequently oscillated between a policy of consolidation and upgradation of existing infrastructure (as the Mudaliar Committee recommended) and a policy in favor of rapid expansion in numbers of primary healthcare infrastructure. In the 6th (1980-85) and 7th (1985-89) Five Year Plans, there was a massive program of expansion of primary health care facilities undertaken. The 8th (1992-1997) Plan re-emphasized a need for consolidation of existing infrastructure rather than financing any further major expansion. The government's policy on rapid increase of primary health infrastructure and its policy on induction of new doctors into the government system have therefore been separate; the massive increase of the former in a decade has not corresponded to a proportionate increase of new doctors into the government system. [See Box 2]

Box 2: Increase in Primary Health Infrastructure relative to increase in numbers of government doctors



Sources: Infrastructure Division, MOHFW, GOI, Rural Health Bulletin, March 2007

Source: Indiatat, MOHFW, GOI

As the first graph above shows, in the decade between 1980 and 1990 the number of PHCs and CHCs increased dramatically. Before 1980, there were between one and two thousand additional PHCs and CHCs every decade. In the eighties, however, over 16,000 new buildings were added to the rural health infrastructure.

The number of doctors, however, grew much more steadily over the last six decades. While the number of doctors did increase in the 1980s as well, the growth did not match that of the infrastructure. The vast expansion in the rural health infrastructure would have required a concomitant increase in the number of doctors to fulfil the staffing requirements of these new facilities. As this did not occur, it likely resulted in an acute shortage of doctors in the public sector and an increase in the number of vacancies. This has important implications for the delivery of health care in rural areas in India.

The Shrivastava Committee (1975) recommended that immediate steps be taken to set up a ***Medical and Health Education Commission***, comprising the Medical Council, Nursing Council and Dental Council representatives of central and state governments, and leading persons in the field of health services and medical education. A *National Education Policy in Health Sciences* was emphasized in the reports of Medical Education Review Committee 1983, the Expert Committee on Health Manpower Planning, Production and Management 1986, and also finds key mention in the 8th (1992-97) Plan for providing the future basis of manpower planning. A Consultative Group under the Chairmanship of Member (Health) of the Planning Commission prepared a draft National Education Policy in Health Sciences. This draft Policy was adopted in the meeting of the Central Council of Health and Family Welfare held in 1993. The 9th (1997-2002) Plan called for an Education Commission of Health Sciences with the assigned responsibility of planning and producing health manpower that is appropriate in quantity to the present and projected needs of the health system. Subsequently, the NCMH Report (2005) and the National Knowledge Commission Report on Medical Education (2007) justified a similar need for a Manpower Commission.

Some ideas of NRHM such as the concept of ***horizontal linkages between the various national disease-control programs*** have their roots in policy proposals that can be traced back even earlier to the 3rd (1961-65) Five Year Plan.¹³ After a gap of a decade, it returns on the policy reform agenda in the Kartar Singh Committee Report proposal of 1973 that there should be integrated training for all workers engaged in the field of health, family planning and nutrition. Similarly, the 6th (1980-85) plan places emphasis on collaboration between programs in water supply, environment, sanitation, nutrition, education, family planning and maternal and child health. By the 9th (1997-2002) Plan and the National Health Policy of 2002, the concept of linkages had progressed to the vision outlined in NRHM that, in addition to inter-sectoral integration, there should also be integration within the health sector between the vertical health and family welfare programs.

Decentralization is another central theme of NRHM that has been prioritized increasingly in recent years. The 7th (1985-89) Plan advocated community participation in health¹⁴, while the 8th (1992-1997) Plan recommended involvement of the Panchayati Raj Institutions (PRI) in health planning. Since then the 9th (1997-2002) and 10th Plans (2002-2007), as well as the National Health Policy in 2002, all make reference towards more decentralized planning and services. The NHP-1983 recommended a decentralized system of health care but it however also stressed that this decentralization be accompanied with a low cost, de-professionalization of the public sector system based more on village-based volunteers, paramedics and community participation. The NHP-1983 judged the exclusive dependence of the public sector health system on state-trained doctors providing service in rural areas to be unrealistic. Instead, the NHP-1983 called for an expansion of the private curative sector, which would help reduce the government's burden. However, such a similar claim of government priority to a community-based provider system *instead of* the government's professional cadres is not shared by NRHM, even though both the

¹³ 3rd Plan: refers to the "possibility of integrating as early as may be feasible services such as those for the control of malaria, tuberculosis, etc., with the normal activities of health units".

¹⁴ 7th Plan: "District-level planning will be introduced towards realizing the objective of promotion of the decentralized planning process"

NHP-1983 and NRHM stress decentralization. Therefore, even when similar larger processes are stressed, a simple focus on broad similarities in different policy statements does not reveal the contrary pulls in conceptual outlook and the nuance of different priorities hidden in them.

Cyclical HRH Policies:

Priority-setting for the country's health policy has also not been consistent over time; some ideas have been dominant at one time and shelved in a subsequent period. That certain aspects of the health system seem to have been considered only intermittently over the years indicate their importance has fluctuated. Some of these key policies relating to human resources are reviewed here separately from the above to show which HRH related policies have reappeared in fresh reform measures.

One significant debate has revolved around whether or not to use **private practitioners in government health care provision**, what type of private practitioners, and to what extent. In the 1960s, the Mudaliar and Mukherjee Committees, as well as the 3rd (1961-66) Plan, recommended part-time use of private practitioners in the government health system. Partnership of the government sector with the private sector was then relatively ignored between the Third and Sixth Plan initiated in 1980, when incentives were proposed for doctors to set up private practice in rural areas and provide part-time service in government hospitals. The principal priority of policy was *efficiency and quality* and a focus on implementation with a *cost-effective approach*, which then called for *more competition* in the system. The 9th (1997-2002) Plan, and all following policy documents through to NRHM, promote collaborations with the private sector as a means to enhance access to quality health care. The 9th Plan suggests creating part-time 'contract' positions, which can be offered to local, qualified private practitioners and/or offer the PHC and CHC premises for after office hours private practice against a rent. The NHP-2002 is even in favor of states 'expanding the pool of medical practitioners to include a cadre of licentiates of medical practice' (GOI, 2002).

As noted earlier, the **proposal for a short term course** for the training of medical assistants or practitioners less than full fledged doctors was given serious consideration in the 3rd (1960-65) Plan as a realistic solution to the problem of insufficient doctors for the rural areas. Because of the opposition from the Medical Council and the doctors lobby, this policy has been shelved to resurface again in the NRHM Task Force Report on Medical Education (2006) and implemented piecemeal in at least one state, Chattisgarh.

The **idea of the multi-purpose health workers or assistants** was proposed as a new category of health personnel and the principal delivery agent of the Minimum Needs Programme (MNP) of the 5th (1974-79) Five Year Plan that called for "an integrated packaged approach to the rural areas" rather than the vertical disease programs. The Kartar Singh Committee (1973) had elaborated the need for a multi-purpose worker (MPW) scheme to convert uni-purpose workers of various vertical programmes into multi-purpose male and female workers who would bring a horizontally integrated package of primary health care delivery to the rural areas. Consequently, the training of ANMs changed away from purely a focus of maternal and child health (MCH). The

7th Plan noted that the training of uni-purpose health workers into multi-purpose functionaries had 'not progressed satisfactorily' and in subsequent plans, the MPW-scheme has not found any mention after having been a core policy. Many states now continue to have MPW (male) with a poor job description and the MPW (female) is once again referred to as the ANM in policy documents, with a renewed focus on MCH activities (Mavlankar, undated).

Another conflict in the history of policy on HRH has been on whether priority should continue to remain on state-produced professional medical staff or shifted entirely to *community-provided health personnel*.¹⁵ The Shrivastava Committee (1975) stated that 'the overemphasis on provision of health services through professional staff under state control has been counter productive' and it instead proposed a Community Health Worker (CHW) scheme. The main recommendation of the committee was to have part-time health personnel selected by the community and from within it. The CHWs were expected to be the link between the MPW at the sub-centres and the community, trained in providing both indigenous and basic allopathic medicine. Although the CHW scheme was initiated with much public interest in 1977 and the central focus of the 6th (1980-85) Plan, by the time of the 8th (1992-97) Plan, it finds no mention.¹⁶ The NRHM revives the concept of a community based 'health-activist' in the form of the Accredited Social Health Activist (ASHA) and it is once again central to the government's preventive and promotive health care plan. An important difference is that the CHW (also called the Community Health Volunteer and Village Health Guide in places) was 90% male, where as the ASHA must be a female; moreover the training of the CHW was 3 months while it has been reduced for the ASHA to 23 days. Moreover, the CHW of the earlier scheme was a paid a regular stipend by the government whereas the ASHA receives monetary benefits on the completion of particular tasks (especially escorting a pregnant mother to an institutional delivery).

The shift in policy thinking towards a community-based health care system in the 1970s brought with it the debate on whether policy calling for *further expansion of medical colleges is justified or not*. The 1979 Alma Ata declaration of 'Health for All by 2000AD', the 1981 ICSSR-ICMR report and the 1983 National Health Policy were part of a similar paradigm of thought as the Shrivastava Report. It is not wholly coincidental that a questioning of the early promise of western medical science to provide miracles in the 1970s occurred alongside a search for other alternatives to health care provision – whether increasing engagement with Indian Systems of Medicine and Homeopathy or a more community-based health system approach. No longer was there complete faith in drugs which had once appeared to be 'magic bullets', but had, by the 1970s, shown to have many unintended consequences (Illich, 1975). The 6th (1980-85) Plan in this context noted 'serious dissatisfaction with the existing model of medical and health services with its emphasis on hospitals, specialization and super specialization and highly trained doctors which is availed of

¹⁵ Opponents to such thinking highlighted ethical concerns of a discriminatory policy that then promoted curative care for urban populations and 'less qualified' preventive care largely for rural populations.

¹⁶ Leslie (1985) holds the failure to use the extensive institutional structure of indigenous medicine for the collapse of the CHW scheme; a separate detailed review of all CHW schemes, including that of India, also considers weakness of institutional support as a key contributory factor in the Indian case (Berman, 1987).

mostly by the well to do classes.’ The Plan diagnosed outright that “this model” was responsible for “depriving the rural areas and the poor people of the benefits of good health and medical services”. In stressing the priority to be a community-based health system, the 6th Plan also stated that there would be no further linear expansion of curative facilities in urban areas and medical colleges. Medical colleges have, however, significantly expanded over the last decade, especially in the private sector, but with approval from government (see Appendix: Figure 2). Currently NRHM expresses the need for further increase in numbers of medical colleges.

A Policy promoting a *University of Medical and Health Sciences in every state* was first proposed by the 1983 Medical Education Review Committee. The 7th (1985-89) Plan initiated the need to establish Universities of Health Sciences with the objective of linking all the training centres and institutions functionally on State, regional and national levels as well as to plan the educational training that different cadres of health workers may need under a single institution. It is thereafter repeated as a priority concern in the 8th (1992-97) and 9th (1997-2002) Plans, but does not feature in the relatively detailed NRHM framework of implementation plan, even as a few such health universities now exist from past policy.

The need to *improve service conditions* of doctors and nurses follows a similar cyclical pattern of importance. In the 1960s, several committees and plans acknowledged the importance of upgrading the service conditions of both doctors and nurses. However, it is not till the Bajaj Committee in 1987 and the High Power Committee on Nursing two years later that this issue is taken up again. Throughout the 1990s the matter is ignored for a second time until the National Commission of Macroeconomics and Health and NRHM advocate transparent guidelines governing Human Resources in Health.

This review of past policy, thus, makes clear that many of the policies put forward by NRHM have been proposed before at various times throughout the last six decades. The reappearance of the same ideas repeatedly over the years highlights their importance. In this context, however, NRHM differs from previous HRH related policy in its scale. NRHM incorporates ideas from throughout the policy history reviewed here, with the individual states expected to prioritize policy in State Project Implementation Plans (PIPs) from a menu of HRH-related policies reviewed here.

Box 3: The ROME Experience: why institutions matter

Under the scheme of Re-orientation of Medical Education (ROME) that is proposed to be revisited again in NRHM, each medical college in the country was to adopt 3 primary health centres in the first phase with the twin objectives of providing a rural bias to medical education and also curative health care and referral facilities to the rural population covered. In the 7th (1985-89) Plan, the Planning Commission outlines the innovative idea of the ROME programme and the reasons for its failure:

The scheme for re-orientation of medical education (ROME) was introduced with the objectives of (i) introducing community bias in the training of undergraduate medical students with emphasis on preventive and promotive services, (ii) reorientation of the role of medical colleges, so that they became an integral part of the health-care system and did not continue to function in isolation, (iii) reorientation of all faculty members so that hospital-based and disease-oriented training was progressively complemented by community-based and health-oriented training for providing comprehensive primary health care, and (iv) the development of effective referral linkages between PHCs, District Hospitals and Medical Colleges. The scheme has been implemented in its first phase, in about 106 medical colleges. In spite of a one-time grant-in-aid to each of the participating institutions, the objectives of the scheme could not be achieved to the desired extent. *This was largely due to (i) lack of commitment to the programme at all levels, (ii) slow progress in the utilization of Central funds, and (iii) absence of efforts in the restructuring of teaching and training programmes at the college levels.*

The clarity with which the 7th Plan took stock on the *content* of the ROME programme explains where the primary focus of the policy planners had been. The diagnosis of reasons for the failed programme, however, emphasizes the importance of the *implementation process*, and why it mattered especially when it received comparatively less attention.

Part II

Institutions as implementation agents of essential HR functions in Health

In the remainder of the paper we use a case study approach. We draw on empirical data from the Central Health Service (CHS) and on the UP and Tamil Nadu state health systems, respectively, to address two separate objectives: a) to understand the HR problem of the CHS, a relatively small, centrally managed service where things might be expected to work better concerning doctor recruitment and attrition; and (b) to examine how two very different states have handled doctor and nurse recruitment in terms of institutional issues and the development of incentives and career tracks for health workers. .

Overview of Case Studies

(a) Central Health Service

The Central Health Service (CHS) was conceived of as a single organised cadre of doctors that would serve in the medical, public health, medical research and teaching posts in central government hospitals, dispensaries, scientific research institutions and institutions of higher medical education. The members of the CHS were also required to serve health-related posts in the Union Territories (under central administrative control) and some autonomous institutions. There are 127 participating units in the CHS.

An important component of CHS is the Central Government Health Scheme (CGHS), which serves as an insurance scheme essentially for central government employees. The CGHS was started in 1954 and at present 24 cities are covered with a total of 9.12 lakh card holders and 33.01 lakh beneficiaries (as on 31.3.2006). 72.5% card holders are serving employees, 25.4% are pensioners and rest belong to categories such as freedom fighters, M.Ps, ex M.Ps, journalists and others. The NCMH Report (2005) notes that 6 per cent of the combined budget of health and family welfare departments (in 2003-4) or 18% of the budget of the Department of Health was spent on 44 lakh beneficiaries or 0.5% of the country's population under the Central Government Health Scheme (CGHS). The CHS is divided into four sub-cadres: (i) Teaching Specialists; (ii) Non-Teaching Specialists; (iii) Public Health Specialists; and (iv) General Duty Medical Officers (GDMO). The GDMOs comprise over three quarters of CHS doctors and are principally employed in CGHS dispensaries.

The significance of choosing the CHS as a case study here is not, therefore, due to a direct relevance of CHS doctors serving the health needs of the majority of people, which is negligible. Rather, the CHS has been chosen as a case study here for two principal reasons: First, the CHS is a medical cadre directly recruited by the central government and the only section of health workforce in the country where the central ministry of health (MOHFW) is directly in-charge of cadre management. Second, the Directorate and other key central institutions (such as NICD, NTI) are led by CHS doctors and therefore the CHS has a very significant managerial and technical role in

relation to health policy formation of the country and oversight of the vertical national health programmes implemented in states.

(b) Uttar Pradesh (UP) State Health System

Uttar Pradesh is the most populous state in India and the health outcome indicators of the state have historically been below the national average. Life expectancy is 59.1 compared with the national average of 62.5. The Maternal Mortality Ratio (MMR) is one of the lowest in the country. The SRS 2000 estimated it at 707 per 100,000 live births, compared with the Indian average of 407. The infant mortality in the State stood at 72 deaths per 1,000 births as compared to the all India average of 58 (SRS 2004).

In recent years, there has been growing interest of the UP state government in health, no doubt helped by substantial increases in financial resources available to the State through NRHM. There has also been a significant increase in the state health budget; the per-capita State Medical and Public Health Budget has increased threefold within five years from Rs.67 in 2001-02 to Rs. 217 in 2006-07 (NHSRC, 2008). As a case study, U.P. is the largest of the northern states lagging in health outcomes and continues to experience significant shortages in human resources for health for both doctors and nurses. The problems in UP call for greater attention consequently, even though empirical data is not easily available and rarely even compiled.

(c) Tamil Nadu (TN) State Health System

Tamil Nadu is a state with a history of greater government attention to the sectors of health and education. In India's federal context, it is positioned as the eleventh largest state in area with the sixth largest population, but also the most urbanized with 44% of its people categorized as such (Census, 2001). It has reported the second lowest decennial growth rate (11.7%) among the states. According to 2006 data, the infant mortality rate in the state was 37 deaths per 1,000 births (with the corresponding all-India figure calculated as 57). Average life expectancy of males is 67 years and of females 70 years, both much higher than the numbers reported for India and for UP above.

There is a significantly improving trend of health indicators such as crude birth rates and death rates, MMR and with institutional deliveries reported in a remarkable 95.6% of births. There is, moreover, a significant narrowing of the urban-rural divide in the IMR trends, which is claimed to be a result of the effectiveness of the government health service provision in rural areas. The case of Tamil Nadu is chosen as it is expected to provide a contrast to UP, but is also a state where implementation problems continue to persist.

Organizational Mapping

A Framework to map essential HRH Functions

This research draws on conceptual tools used separately in political economy and health systems studies to analyze institutions as implementation agents of essential human resource (HR) functions in Health.¹⁷ In developing this framework for organizational mapping, an approach to institutional analysis and to policy process is juxtaposed with a diagnostic approach to health systems that is focused on HR-related functions.

This framework is useful to supplement the “thick” description of particular cases related to HRH into the context of comparable health systems analysis. One recently published diagnostic framework for health systems (Roberts et al (2004)) provides a powerful tool to assess overall health-system performance – a component of which is “organization”, in which many HRH issues are situated. Recent work by the WHO (2006) and the Joint Learning Initiative (JLI, 2004) have developed separate conceptual frameworks for specifically addressing human resource actions in the health system and how they relate to health system goals and to health outcomes.

These frameworks, however, have a broader scope than an institutional focus, which is the aim of this paper. On the other hand, analytical toolkits published by DfID (2003) and the World Bank (2007) provide general useful guidelines for institutional analysis that can be applied to the health system. For our framework, we draw from these different sources and especially from Martinez and Martineau (1998), which defines five essential functions related to human resources for health (HRH).

These core functions diagnosed are considered necessary for a health system to operate effectively and efficiently with regards to HRH issues. For example policymaking, which consists of making decisions about various aspects of the health system such as allocation of funds, employment regulations, new training institutes, and the setting of staff norms, is a crucial function that needs to be carried out by certain organizations in the health system. Other essential functions include the production of new health workers, Personnel Administration, Performance Management, Regulation, and Finance. These functions and their components are described in further detail in Table 1 below:

These core human resources related functions are utilised here in a framework that allows us to map a single or a cluster of organizations tasked with the implementation of each of these functions. This provides a *static mapping* of the institutional context. With regard to the coverage (density and distribution), motivation and the competence of any cadre of health personnel in the system, it is the characteristics and performance of the concerned institutions that then largely determine how far these cross-cutting HRH objectives are achieved. The link between this framework of key HRH functions and the institutional context to health system goals (efficiency, equitable access) and to health outcomes is diagrammatically presented in the Appendix Figure 1.

¹⁷ Refer back to the analytical approach initially outlined in this paper, p.2.

Table 1: Essential HRH Functions in the Health System

Core function		Function components
<i>Policy</i>		<ul style="list-style-type: none"> - Policymaking with regard to: <ul style="list-style-type: none"> ▪ Allocation of funds ▪ Employment regulations ▪ New training institutes ▪ Other HRH issues - Setting staff norms
HRH Production	Staff Supply	<ul style="list-style-type: none"> - Recruitment of health workers - Allocation of health workers
	Education & Training	<ul style="list-style-type: none"> - Education - Setting curriculum - Continued training for upgradation of skills
Organisation/ Management	Personnel administration	<ul style="list-style-type: none"> - Administration of: <ul style="list-style-type: none"> ▪ Promotions ▪ Transfers ▪ Staff grievances ▪ Disciplinary action - Maintaining informational records on staff
	Performance Management	<ul style="list-style-type: none"> - Monitoring and Evaluation of: <ul style="list-style-type: none"> ▪ Job descriptions ▪ Health worker supervision ▪ Performance-based incentives for staff ▪ Contracting staff
Regulation		<ul style="list-style-type: none"> - Enforce and monitor legislation on: <ul style="list-style-type: none"> ▪ Multiple job-holding ▪ Geographic mobility of health workers - Accreditation of training institutes - Registration of health personnel
Finance		<ul style="list-style-type: none"> - Provision of funds for implementation of policies

Organizational Mapping of key HRH Functions applied to the selected Cases

In this section of the paper, our framework is applied to map organizations that carry out the key HR-related functions for Central Health Service (CHS) doctors and for government medical doctors and nurses in the government system of Uttar Pradesh (UP) and Tamil Nadu (Tables 2-4 below). While a mapping of organizations to functions is a useful overview of the institutional context, it is principally a snapshot of the organizations involved and does not inform on how they interact with each other to carry out a function. In the final section of Part II, we take the recruitment process of doctors into the CHS and into the government medical services of UP and Tamil Nadu as an illustrative example of how the implementation process of an important HRH function occurs in three different contexts involving different sets of organizations.¹⁸

HRH functions are principally shared in health systems across the country between the policymaking administrator-bureaucrats (located in the Central Ministry or state health Secretariats) and administrator-doctors who are also the technical support for the policymakers (located in the central DGHS or State Directorates). In the organizational maps for the states below, both central level and state level organizations are mapped. An analysis of the organizational maps follows the tables below.

¹⁸ For more details on the methodology of static mapping and process mapping, see World Bank (2007)

Table 2: Organization Mapping of the CHS

Core function		Function components	Mapped Organization
Policy		Allocation of funds	Principal Secretary, Financial Advisor Cadre Controlling Authority - CCA (Ministry)
		Employment regulations	Principal organization: CCA, (Ministry). For change in CHS Rules, permission needed from Dept of Personnel & Training (DOPT), Ministry of Finance
		Setting staff norms	DOPT, CCA (Ministry) and changes with permission of UPSC
HRH Production	Staff Supply	Recruitment of CHS Doctors	CCA (Ministry) and UPSC
		Allocation of CHS Doctors	CCA (Ministry)
	Education & Training	Continued Education & Further Training for CHS Doctors	DGHS (Medical Education wing)
Organisation/ Management	Personnel administration	Promotions	For 2 senior-most grades, UPSC; MOHFW informs UPSC of vacancies For all other promotions, DPCs formed in MOHFW guidelines by DOPT
		Transfers	Principal organization: CCA, (Ministry). Committee constituted under DGHS for transfers up to CMO grade
		Staff grievances	Vigilance Officer for CHS (DGHS) CCA, (Ministry)
		Disciplinary action	Approval from Minister
		Maintaining informational records on staff	CHS-5 wing in CCA, Ministry
	Performance Management	Job descriptions	CCA, (Ministry)
		Health worker supervision	Not well defined; a 'compendium' only for CGHS states what each rank should do
		Performance-based incentives for staff	Only through the mechanism of ACR maintained in CHS-5 wing of CCA
		Contracting staff	No Contracting of staff but small number of Deputations from State at CMO-level up to Director-level, by CCA
Regulation		Registration of health personnel	No separate registration of CHS doctors (Registered in different state councils before applying)
Finance		Provision of funds to institutions and payment of salaries	Decentralised to participating institutions and to CGHS

Table 3: Organization Mapping of the Medical Doctor Cadre in UP and TN Government Health Systems

Core function		Function components	Central Level	UP	TN
Policy		Allocation of funds		S(H), SFM	S(H), SFM
		Employment regulations		To amend Service Rules, S(H), SFM, DA	S(H)
		New Medical Colleges	DGHS (for Centre-managed institutions), MCI, MoH,	C, S(H)	C, S(H)
		Setting staff norms	MCI (in Medical Education), Ministry/DGHS	S(H), SFM	S(H), SFM
		Recruitment of Doctors		S(H), D(Admn), D(W), SPSC	DPH, SPSC
HRH Prod.	Staff Supply	Posting of Doctors		S(H)	DPH, SPSC
		Admission to Medical Colleges	Med Ed. wing, DGHS for All-India quotas of seats	D(ME) – for State quotas of seats	DME
	Edn. &Trng.	Setting curriculum	MCI		TN MGR Univ.
		Continued training for skill upgradation	NAMS, NIHFw (possible, but rare) Professional Associations	No organization currently tasked	Medical Colleges are tasked
		Further New Training		In service training only for PG-diploma: D(PBT)	DPH, DMS
Org/ Mgmnt	P.Admn.	Promotions		S(H) For higher 2 grades; D(Admn), D(W) for lower grades	S(H), DPH, DMS through Counselling
		Transfers		S(H). In recent years, D (only for Class 2 doctors, Level 1 & 2; with approval from Secretariat)	S(H), DPH, DMS through Counselling
		Staff grievances		D	D
		Disciplinary action		Only S(H); either Secretary (health) or Principal Secretary	Special Confidential Section of each Directorate, S(H)
		Maintaining informational records on staff		S(HFW): Sec.2, higher lvls & Sec 3 (lwr lvls) Sec 11 (lady doctors). D(A): Sec1 and Sec 2 (male doctors), D(W)	Heads of Institutions reporting to DPH, DMS
	Perform. Mgmnt.	Job descriptions		No organization currently tasked	As per Tamil Nadu Medical Code. No organization tasked to update
		Regular supervision		No organization currently tasked	D, Tasked to heads of Institutions
		Performance-based incentives		Only as ACRs – D(A), D(W)	Only as ACRs, no organization tasked
		Contracting staff		District-level committee (incl. DM, CMO)	Employment Exchange, DPH
		Accreditation of Medical Colleges	MCI		TN MGR Univ.
Regulation		Registration of doctors		SMC (State Medical Faculty)	SMC

Key used in Table 3

General Key

S(H)	Secretariat (H&FW) or Health Department
SFM	State Finance Ministry
DA	Doctors' Association
C	State Cabinet authorization
MoH	Central Ministry of Health
MCI	Medical Council of India
DGHS	Directorate General of Health Services
SPSC	State-specific Public Service Commission
D	Directorate
NAMS	National Academy of Medical Sciences
NIHFW	National Institute of Health & Family Welfare
SMC	State-specific Medical Council

UP-Specific Key

D(Admn)	Directorate (Administration)
D(W)	Directorate (Women cells)
D (PBT)	Directorate (Plan, Budget & Training)
D(GC)	Directorate (Grievance cell)

TN-Specific Key

DPH	Directorate of Public Health and Preventive Medicine
DME	Directorate of Medical Education
DMS	Directorate of Medical and Rural Health Services

Table 4: Organization Mapping of the Nursing cadre in UP and Tamil Nadu Government Health Systems

Core function		Function components		Central Level	UP	TN
Policy		Allocation of funds			S(H), SFM	S(H), SFM
		Employment regulations			S(H)	S(H)
		New Nursing Schools		INC (inspection)	S(H)	DME
		Setting staff norms		INC (in Education)		DME, DMS
		Recruitment of Nurses			D(MC), S(H) for final authorisation	DMS
HRH Production	Staff Supply	Allocation of Nurses			D (MC); S(H) for top two nursing positions at the Directorate	DMS
		Admission to Nursing Schools			D(MC)	DME
	Education & Training	Setting curriculum		INC		
		Continued training for upgradation of nursing skills and further new training			No refresher-training avenue in existence. For Further training, no organization currently tasked (Earlier, Directorate sent nurses for further training)	TN MGR Univ., NGOs
		Promotions			D(MC) for gazetted grades, CMO for non-gazetted grades	Tasked to D, with S(H) designated authority
Organisation/ Management	Personnel administration	Transfers			D(MC)	DME, DMS
		Staff grievances			D(GC)	
		Disciplinary action			D (all grades)	S(H), DME, DMS
		Maintaining informational records on staff			D (section 17), but record keeping is poor	Institutions reporting to DMS, DME
		Job descriptions			No organization currently tasked	As per Tamil Nadu Medical Code. No organization tasked to update
	Performance Management	Regular supervision			No organization currently tasked	D, Tasked to heads of Institutions
		Performance-based incentives for staff			Only as ACRs – D(MC)	No organization currently tasked
Regulation		Contracting staff			District Committee (incl. CMO, DM)	DMS (appointing authority)
		Accreditation of Nursing Schools		INC		SNC
		Registration of Nurses			SNC (State Medical Faculty)	SNC

Key used in Table 4

General Key

S(H)	Secretariat (H&FW) or Health Department
SFM	State Finance Ministry
CMO	Chief Medical Officer
INC	Indian Nursing Council
D	Directorate
SNC	State-specific Nursing Council

UP-Specific Key

D(MC)	Directorate (Medical Care cell)
D(GC)	Directorate (Grievance cell)

TN-Specific Key

DPH	Directorate of Public Health and Preventive Medicine
DME	Directorate of Medical Education
DMS	Directorate of Medical and Rural Health Services

Analysis of Tables 2-4:

What do we find from Organizational Mapping?

1. Cases of single organization or multiple organizations undertaking a similar task

For CHS doctors, the Cadre Controlling Authority (CCA) in the Ministry of Health and Family Welfare is the organization tasked with most of the functions. In the case of doctors in the UP government medical service, there are multiple sections of the Directorate (Health) and the Directorate (Medical Education) as well as the Secretariat involved, sometimes for the same function. This reduces accountability of any single organisation involved in the implementation of the task. In the case of nursing in UP, most functions are undertaken at the Directorate and the Secretariat is much less involved than it is with the medical doctor cadre. There is also less organizational development for undertaking key HR functions relating to the nursing cadre. The situation is comparatively better in Tamil Nadu. Although there are three Directorates (Public Health, Medical Education and Medical Services) in Tamil Nadu that require doctors to be recruited to serve their functions, it is only the Directorate of Public Health (DPH) that is authorised to be the nodal recruiting body for doctors into Government Service. Doctors recruited by the DPH are then deputed to the other two Directorates. There remain, however, separate training cells in each of the Directorates.

2. Administrative function relating to both teaching and non-teaching doctors in the Service linked within a single authority, totally separated or 'somewhat linked'

The Cadre Controlling Authority is charged with the administrative function relating to both teaching and non-teaching doctors in the CHS. This is not so in UP, where organizations responsible for HRH functions concerned with medical health service are entirely distinct from those concerned with medical education. The administrative functions relating to doctors in the UP Provincial Medical Service (PMS) come under the purview of the Secretariat (H & FW) and the Directorate (Health). The administrative functions relating to teaching-doctors in medical colleges is managed entirely separately and come under the purview of Secretariat (Medical Education) and Directorate (Medical Education). The organization map in Table 3 considers only the complex allocation of responsibilities in the Provincial Medical Health Service, and not medical education as well, to avoid confusion. In Tamil Nadu, while there are distinctly separate Directorates for non-teaching doctors (DMS and DPH) and teaching doctors (DME), there is a single Secretariat to which all Directorates are linked. In all three cases – CHS, UP and TN – the administrative/policy functions concerning teaching and non-teaching doctors are, therefore, organised differently and accountability of particular organizations to tasks, again, vary.

3. Institutional provision to oversee and conduct continuing education and further training is either weak (CHS doctors, UP doctors) or non-existent (UP nurses)

For CHS doctors, the medical-wing in the Directorate recommends doctors for further training. However, it neither has the capability to provide the training itself, nor is any other organization tasked as the nodal agency for such further training to CHS doctors. In UP, no organization tasked to undertake CME for government doctors

exists at all, although government institutions and professional associations at the central level do provide the possibility of CME. There, however, does exist a separate cell (Plan, Budget & Training) in the Directorate with other unrelated functional responsibilities which is also additionally tasked with managing further training of doctors. For nursing in UP, there is no existing organization tasked with the function of facilitating or providing continued education to in-service nurses. In Tamil Nadu, however, CME is organized periodically in all medical colleges and the Directorate of Medical Education does not directly oversee the facilitation of CME for doctors.

4. No organizations is/are tasked with ensuring a regular supervision system of the health worker is in place and functioning, with a single possible exception in Tamil Nadu

There is an absence of organizations in the CHS or in UP tasked with the function of overseeing that a regular supervision mechanism of health personnel (doctors and nurses) is operational. One exception is the Directorate of Public Health (DPH) in Tamil Nadu, where there has been a systematic supervisory structure that is operational with monthly District-level Review Meetings on public health officials functioning within a district, including 'surprise' inspections that check for absenteeism.

5. In all three cases, performance of a doctor or nurse is only transmitted through the Annual Confidential Report (ACR). There is no organization, as such, tasked with monitoring performance

In all three cases, performance of the doctor or nurse is only through the Annual Confidential Report (ACR). There is no organization, as such, tasked with monitoring performance of CHS doctors or UP doctors and nurses. The concerned organization with this function in all three cases is principally the repository where copies of ACRs should be available. Therefore, while performance monitoring and related incentives receive much policy interest, there is little, if any, organizational capacity or corresponding institutional context that exists or is fostered.

6. Organizations clearly charged with maintaining or evaluating the job descriptions relating to the different posts are not present for all jobs in all three cases

In UP, there exist posts for which no job description has as yet been formalised (the post of Additional CMO is a case in point). For the Public Health Nursing cadre in UP, no clear job descriptions exist for *any* of the posts. In contrast, all posts of doctors and nurses in Tamil Nadu have laid-down job descriptions. In the CHS, *only* GDMOs are covered by clear job descriptions. In all three cases, however, there exists no organization to maintain and update, on any regular basis, the job descriptions that do exist.

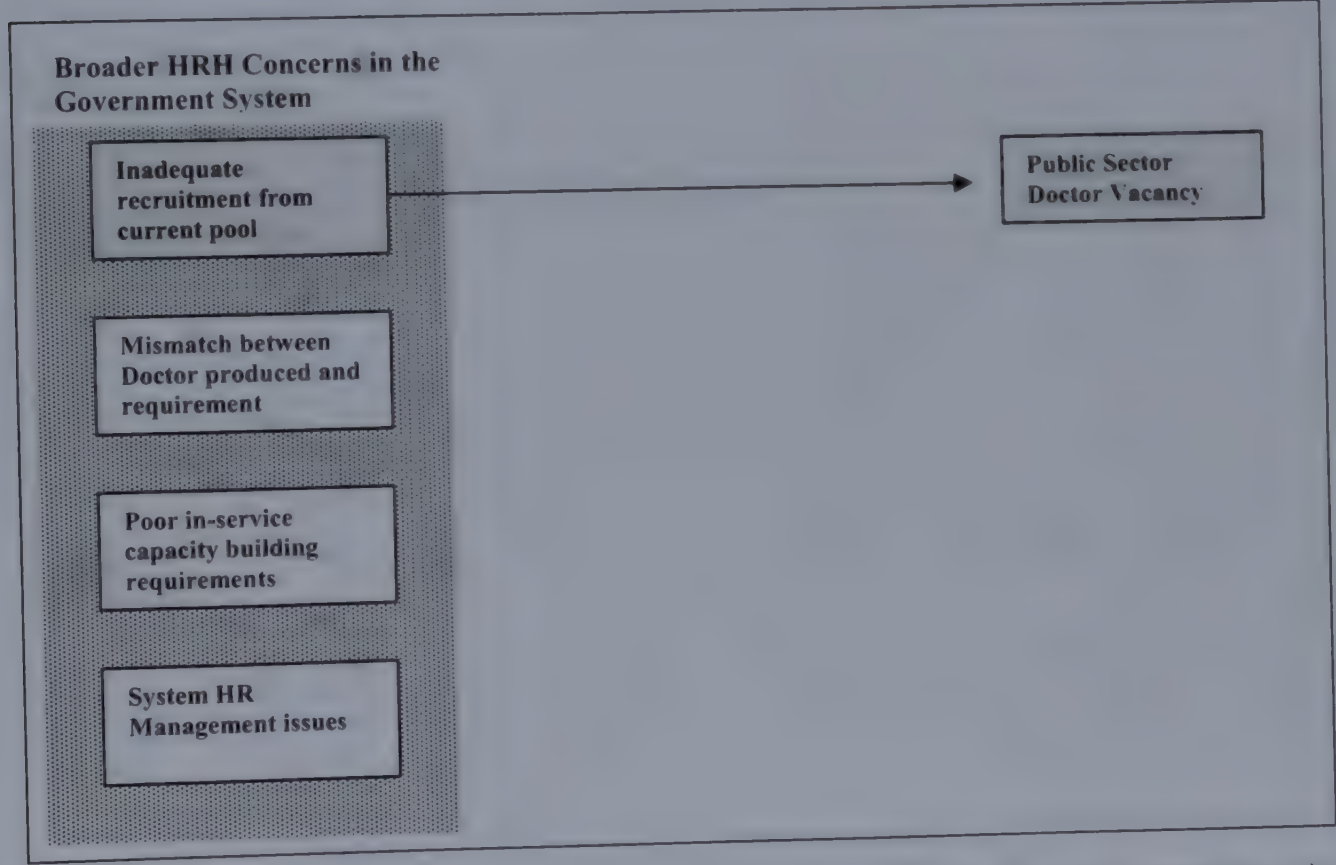
7. Much more central level involvement in the HR-functions concerning state-level doctors relative to such central involvement in the cases of the nursing cadre

In both UP and Tamil Nadu, in fact, largely most functions relating to nursing are further relegated to the directorate level, without much engagement of the Secretariats.

Organizations at work: Recruitment process of doctors in CHS, Uttar Pradesh and Tamil Nadu

In this section, the recruitment process of doctors into the UP and Tamil Nadu Government Medical Service and into the Central Health Service (CHS) is taken as illustrative examples of how organizations are involved in the implementation of a significant HR function. Moreover, in the context of NRHM, the recruitment of *more doctors* is a key policy measure to not only fill large-scale vacancies, but also to meet the new Indian Public Health Standard (IPHS) norms that call for many more doctors at the health facilities. The number of doctors to be recruited into the government health system depends on the number of existing vacancies in relation to the officially sanctioned posts.¹⁹ Recruitment, therefore, relies on the extent of public sector doctor vacancy. Since it is the *recruitment process* that is our focus as an illustrative case, Figures 1 and 2 shows how we conceptually approach the matter. In Figure 1, public sector doctor vacancy is singled out and located in the context of broader HRH concerns in the government system, which *all* have a bearing for doctors in government service. In Figure 2, the recruitment process is located as one among various other contributing factors to the Public Sector Doctor Vacancy problem.

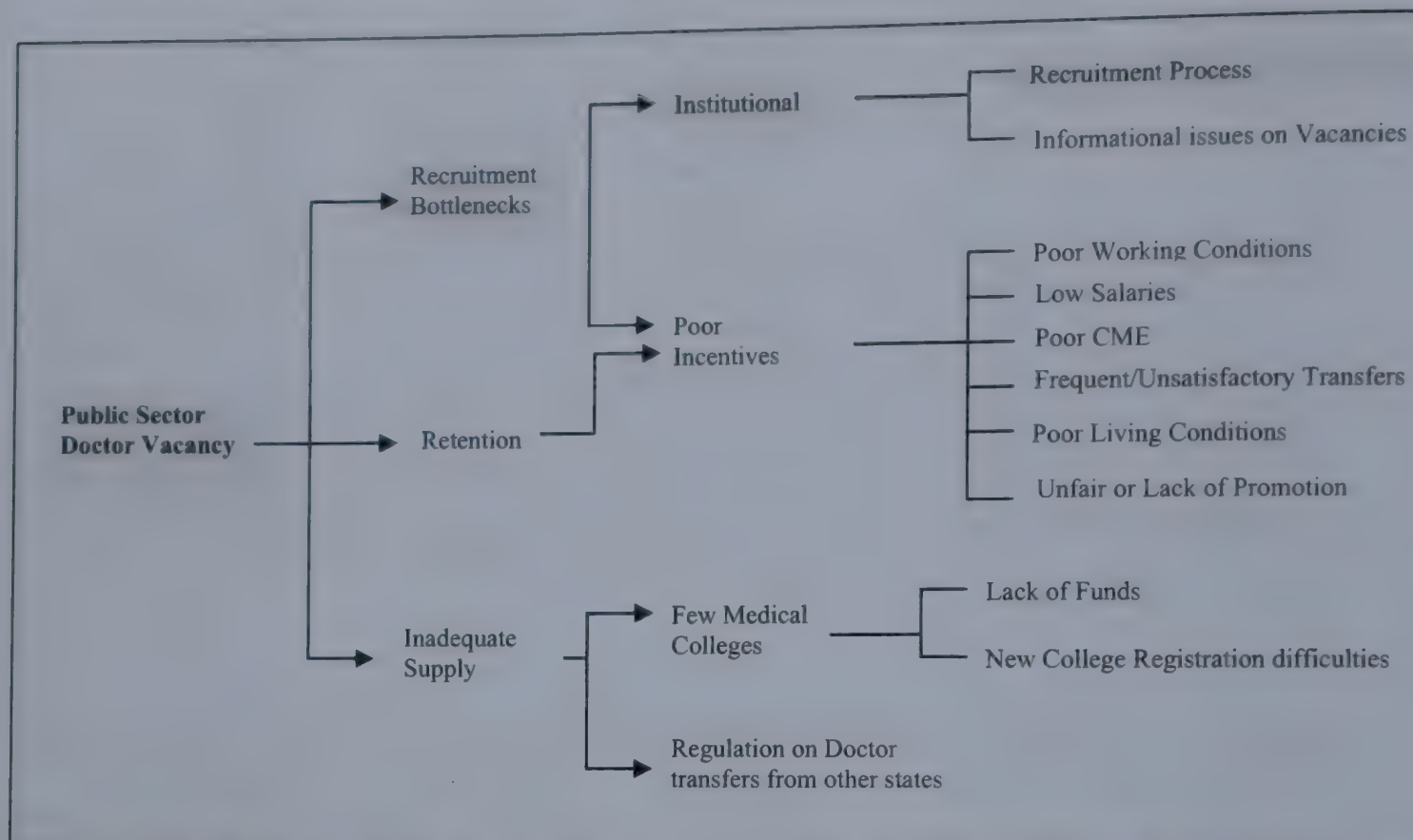
Figure 1: Doctor Vacancy in context of broader Government HRH concerns



Adapted from T. Sundararaman, “NRHM and Human Resources for Health”, presentation in IIM Ahmedabad, January 2008

¹⁹ The government’s norms for health manpower requirement are supposed to be computed on the basis of the population. The 9th (1997-2002) Plan suggested that the requirement of personnel be computed not only on the basis of population, but also on the basis of workload, distance to be covered and difficulties in delivery of Health Services. In practice, finances play an important role in determining the actual number of posts sanctioned.

Figure 2: Recruitment Process in the larger Doctor Vacancy diagnostic tree*



* Other factors not shown in the chart, such as adequate and timely financing, also contribute causally to doctor vacancy, but they are not the subject of this paper and so not included here.

Uttar Pradesh: Doctor Recruitment Process

The UP Government sends the UP Public Services Commission (UPPSC) a requisition order for posts that require to be filled by eligible candidates. The requisition from the UP Government is scrutinized by the UPPSC on two principal grounds. First, the Commission checks whether the terms and conditions of the posts that are being requisitioned are on the basis of the existing Service Rules of the particular cadre. If the scrutiny finds small aberrations, such as a difference in only the nomenclature used by the Government requisition and the Service Rules, these minor differences are cleared without causing much delay. However, if major discrepancies are found between Service Rules and the requisition, the latter is returned to the Government and cause of certain delay. A second significant ground on which requisitions come to be scrutinized by the Commission relates to whether the Government requisition is in compliance with the current reservation policy of not more than 50% posts in favor of reserved categories (Scheduled Castes, Scheduled Tribes, Other Backward Classes). The Government is *prone to overrepresentation* of the numbers requisitioned for reserved groups, which is then deemed illegal by the Commission.

After the requisition passes the scrutiny of the Commission, the latter places an advertisement with fixed time-frame as a deadline. The length of time till the deadline changes with the size of the requisition and all responses must be received

within that time. The responses are then scrutinized by the Commission. The Government and the Commission decide jointly on which advertised jobs and responses to these will be looked at first as a matter of priority. The selection process through interviews takes place and recommendations are made from the Commission to the Government of the successful candidates.

The data collected from UP show that in the case of specialists, there is a significant decline in numbers between the stages of those who respond and those who are selected by the Public Services Commission. For instance, in Table 5, of the 100 anaesthetists who responded to the advertisement for 95 advertised vacancies, 38 were initially selected and finally 31 recommended to the Government. The principal reasons for such few numbers chosen by the Commission over those who initially responded are as follows: 1) the scrutiny of the responses reveal that the candidates did not all meet the minimum eligibility requirements of educational qualification and other experience required by the Service Rules; 2) the candidates claim to have the required educational qualification, but the degree is not recognized by the MCI and consequently deemed invalid by the Public Services Commission. For instance, a postgraduate, say, from Gorakhpur Medical College in 2005 when none of the PG seats there were MCI-recognized, would be eliminated from joining government service at this stage (see table in Box 6 below). There is no one single procedural timeline set out for each of the stages in the entire recruitment process. On average, from the point of advertisement to a person joining the service, one-year-and-a-half is taken.

Table 5: Requisition of Posts received in 2005 and Selection data by the UPPSC

S.No	Name of Post	Requisition of Posts rec'd from Govt.	Category of Posts to be filled					Number Responses rec'd by UPPSC	Number Selected by UPPSC	Number recommended by UPPSC to Govt.
		III	General	OBC	SC	ST	VIII		IX	X
I	II		IV	V	VI	VII				
1	Medical Officer (General - Male)	1239	619	336	360	24	5326		1220	1220
2	Medical Officer (Specialist - Male)	420								
	Anesthetist	95	47	27	20	1	100		38	31
	Radiologist	125	63	34	26	2	36		10	10
	Pathologist	105	52	29	22	2	49		13	13
	Cardiologist	68	34	19	14	1	92		-	-
	Chest Physician	27	13	8	6	-	79		21	19
3	Medical Officer (Specialist Female)	-								
	Anesthetist	369	30	17	13	1	44		13	11
	Radiologist	61	32	17	14	1	19		5	5
	Pathologist	64	20	12	8	-	82		23	20
	Obs & Gyn	40	102	55	43	4	447		145	93
	Totals	2028					6274		1488	1422

Source: Uttar Pradesh Public Services Commission, Allahabad

Table 6: Government Appointment letters sent on Requisition of Posts made in 2005-06

S.No	Name of Post	Requisition of Posts rec'd from Govt.	Number Selected by UPPSC	Number recommended by UPPSC Govt.	Shortfall number recommended by UPPSC	in Number Govt. appointment letters sent	of Number who have joined
I	II	III	IV	V	VI	VII	
1	Medical Officer (General - Male)	1489	1467	1448	41	1411	
2	Medical Officer (Specialist - Male)	592					
	Anesthetist	139	38	31	108	31	
	Radiologist	167	10	7	160	7	
	Pathologist	105	13	13	92	13	
	Cardiologist	68	-	-	68	-	
	Physician	54	-	-	54	-	
	Surgeon	42	-	-	42	-	
	Chest Physician	17	21	19	0 (+2)	19	
3	Medical Officer (Specialist - Female)	369					
	Anesthetist	61	13	11	56	11	1*
	Radiologist	64	5	5	54	4	0*
	Pathologist	40	23	20	20	19	2*
	Obs & Gyn	204	145	92	112	90	26*
	Totals	2450	1735	1645	805	1608	

*Denotes currently available data from the periphery on number of doctors who have joined.

Source: U.P. Ministry of Health, corroborated with data from Directorate, Administrative Unit and Women Cell

In Table 6 above, the number of Government appointment letters is marginally lower than the number recommended by the UPPSC in the case of General Medical Officers, as the Directorate finds incomplete records existing for some. However, in the case of Male Specialists (where the numbers are already significantly lower than requirement), the number of appointment letters sent match the numbers that the UPPSC recommended and no issues are raised at the Directorate or Secretariat. Data on numbers who finally join the government medical service are not available at all for Male General or Specialist sub-cadres, since the information needs to be collected from the periphery, whether the Chief Medical Officer in the district or the Chief Medical Superintendent in the district hospital for specialists in that hospital. For the Female Specialist sub-cadre, incomplete data available so far reveals that of those doctors sent appointment letters, a very small proportion actually report for duty. The posts remaining vacant due to the assigned new doctor not reporting for duty are

declared vacancies in the requisition for the next round of recruitment, the results of which require another wait for a year-and-a-half.

CHS: Doctor Recruitment Process

The recruitment procedure for doctors in the CHS is nearly identical to the procedure in UP. A notable difference between the recruitment procedure of doctors in UP and in the CHS is that in the case of the former, the UPPSC does not conduct any entrance examination while the Union Public Services Commission (UPSC) at the Centre does, in addition to the oral interview process of candidates common in both recruitment processes. The nodal recruitment authority in the CHS is the Cadre Controlling Authority (CCA) in the central ministry of health that sends the requisition of doctors to be recruited to the UPSC. Between 2000 and 2004, there was no recruitment due to a central ban on all UPSC recruitment that was lifted exceptionally for central medical services, such as for Railways, Defence, MCD and the CHS.

Table 7: Recruitment of General Duty Medical Officers (GDMO) – recent years

CMSE Batch	Requisition sent to UPSC MOs for	Total Number of candidates received from UPSC*	Candidature cancelled (before issue of offer letter)	Number of offers issued	Offers Cancelled	Candidates Joined	Candidates yet to join
I	II	III	IV	V	VI	VII	VIII
2004	200	168	32	136	80	53	3
2005	300	275	80	195	118	59	18
2006	300	238	9	119	0	25	94
2007	200	Dossier of Successful Candidates not received by Cadre Controlling Authority, MOHFW from UPSC. Allocation of cadres will be made thereafter.					

*All successful candidates received the approval of the Minister of Health & FW

Source: Cadre Controlling Authority, MOHFW, New Delhi

In Table 7 above, after successful candidates from UPSC are approved by the Minister for offer letters, there is still a notable cancellation of candidatures prior to the offer letter being issued. There are three main reasons provided by the Cadre Controlling Authority for cancellations at this stage in the recruitment process: 1) the candidate is found personally medically unfit in the second medical examination that follows the UPSC interviews; 2) the candidate’s file is marked as an “Offer Not to be Issued” – as a ONI Case - because the candidate fails to provide original or verified documentary proof of educational qualifications; and 3) the candidate does not appear before the Medical Board for the mandatory second detailed medical examination to decide personal fitness.

The significantly large numbers of offers cancelled are, however, after offer letters have been issued. This is because the candidate has opted instead for a postgraduate course of study during the time taken in the recruitment process. At least 10% to whom offer letters have been issued provide no response at all and so their offer is cancelled. All offers lapse after a period of 6 months from the date of issue of offer

letter. The process from the time of the candidate's response to the advertisement till the offer letter being issued is on average over a year. Much like in UP, the entire process from requisition to a candidate joining takes at the very minimum a year-and-a-half; the majority of this time is between the candidate taking the Central Medical Services Examination in February and the UPSC providing the Ministry with its recommended list of candidates. Therefore, the CHS, although managed by the central government with significant political intention and finances to recruit more doctors, is plagued by a recruitment process as lengthy as the recruitment process in the government medical service in UP.

Table 8: Recruitment of Specialist sub-cadres in CHS (since recruitment resumed in 2005)

	Specialist Sub-Cadre	Number of requisitions sent to UPSC	Number of successful candidates from UPSC	Approval by Minister	Offers Sent	Candidates Joined
1.	Teaching	255	125	123	111	77
2.	Public Health	25	10	10	9	4
3.	Non-Teaching	123	76	73	69	45

Source: Cadre Controlling Authority, MOHFW, New Delhi

In Table 8 above, for the Teaching sub-cadre, 62.6% of those who received offer letters joined, but this still translates into only 30.1% of the requisitioned posts being filled. For the small Public Health sub-cadre, 40% of successful candidates joined, but only 16% of the requisitioned posts were filled through the recruitment rounds. Finally, for the Non-Teaching Specialist sub-cadre, 61.6% of the candidates sent offer letters indicated they would join, which would fill 36.5% of the requisitioned posts.

Tamil Nadu: Doctor Recruitment Process

It is noted above that the recruitment process in UP and CHS differ in one respect: there is no entrance examination that the UPPSC conducts for UP candidates, while at the Centre, the separate central UPSC conducts a common entrance examination. In Tamil Nadu, the recruitment process of doctors is further different in this respect as not only is an entrance examination an important prerequisite before the oral interviews, this is *not* a single examination; instead, there is a separate entrance examination designed for each specialty.

The data in tables 9 and 10, however, reveal that the trends observed in UP and CHS above are not very different from the trends found in Tamil Nadu, which is a state with much better health indicators than UP. First, much like in UP, there appears to be still a large number of MBBS-only students that respond to an opening to be a doctor for General Medicine in the Government service. The numbers that actually

report for duty, nevertheless, are lower than the number of posts that the doctors were being recruited for. Therefore, vacancies persist even at the end of a recruitment round. Second, the shortfall in the number of respondents to openings in particular specialties is particularly remarkable. In Table 9 and 10, the very few number of trained specialists who responded to openings for Anatomy, Community Medicine (Public Health), Physiology and Biochemistry are notable. Much like in UP, there is a direct correspondence between the lack of doctors trained in such specialties joining the Government Service and the shortage of faculty in these particular departments in government medical colleges, promoting a vicious cycle. Third, in Tamil Nadu as in UP and other states in general, the reservation of jobs along social community lines and the absence of trained doctors from these communities result in peculiarities where even when there are a surplus number of respondents to Anaesthesiology posts (see Table 9), the actual numbers selected are still short of the numbers required at the time. Even fewer finally join to take up the posts.

A significant cause for the fewer numbers joining remains the length of time taken for the recruitment process, even in Tamil Nadu, for the recruitment of doctors through the Public Services Commission. With other opportunities for doctors, the length of the recruitment of nearly a year allows doctors to look for other opportunities, especially the attraction of successfully enrolling into a PG-course of study for MBBS-only doctors. Governments, both at the Centre and States, have looked to the possibility of contractual doctors to address the vacancies existing in government health services but as the next section observes, the results have been mixed.

Table 9: Requisition of Posts received in 2003 and Selection data by the TNPSC, Tamil Nadu Government

Name of Post with year of selection	No. of posts notified	No. of candidates applied	No. of candidates appeared for the written examination	No. of candidates summoned for the Oral Test	No. of candidates who appeared for Oral Test	No. of candidates selected	No. of candidates reported for duty
2003 – 2004	I	II	III	IV	V	VI	VII
General Medicine	1295	7123	5368	2586	2428	1295	1107
Specialities				431	83	57	49
Anaesthesiology	60						
Anatomy	53						
Bio Chemistry	25						
Community Medicine	38						
Dermatology	9						
E.N.T.	10						
Forensic Medicine	34						
Micro Biology	23						
Nephrology	10						
Neurology	2						
O & G	20						
Orthopaedics	20						
Ophthalmology	13						
Pathology incl. BB	53						
Paediatric medicine	11						
Pharmacology	28						
Physiology	46						
Physical Medicine	10						
Psychiatry	20						
Radiology	25						
Thoracic Medicine	20						

Source: Tamil Nadu Public Services Commission, Tamil Nadu Government

Table 10: Selection data by the TNPSC, Tamil Nadu Government for 2002-3 normal round, 2003 Special Qualifying Examination and previous years

Name of Post with year of selection	No. of posts notified	No. of candidates applied	No. of candidates appeared for the written examination	No. candidates summoned for the Oral Test	No. candidates who have appeared for Oral Test	No. of candidates selected	No. of candidates reported for duty
	I	II	III	IV	V	VI	VII
2002-2003							
General medicine	305			610	573	305	219
Anaesthesia	20				47	20	14
Anatomy	20				7	7	7
Bio Chemistry	15				10	10	10
Community Medicine	14				4	4	4
Forensic Medicine	20				3	3	3
Micro Biology	20			203	13	13	13
Pathology	20				31	20	17
Pharmacology	20				14	14	14
Physiology	20				8	8	8
Psychiatry	10				23	10	6
Radiology	20				32	20	13
General Medicine (Special Qualifying Examination) 2003	-	546	530	521	521	516	516
General Medicine (Exclusively for Women) 2000-2001	350	2664	2370	694	625	340	300
General / Speciality, 1999	778	7354	6156	1552	1430	778	620

Source: Tamil Nadu Public Services Commission, Tamil Nadu Government

Experience in Contracting Doctors as an Alternative to Regular Recruitment

The lengthy recruitment process is considered by NRHM as a significant bottleneck to the immediate requirement of filling existing doctor vacancies. NRHM therefore promotes the option of contractual doctors who can be recruited instantly in a walk-in interview that is held weekly. There is no arrangement of contractual doctors in the CHS. However, the state governments in both UP and Tamil Nadu have used the practice of recruiting doctors on a temporary contractual basis to expedite the recruitment process of doctors. The two states have had very different experiences with this practice of contracting doctors.

Uttar Pradesh

In UP, recruitment of contractual doctors is undertaken at the district-level through a committee that includes the District Magistrate (DM) and the Chief Medical Officer (CMO). The Directorate is informed about any new recruitment. The scheme has however been mostly unsuccessful. The contractual doctors could be trained in either allopathic medicine or in AYUSH. Initially, it required the doctor on contract to work eight hours in the public health centre and he was paid a third less than an entry-level doctor in regular government service, since he was permitted private practice. There were very few takers for such contractual positions, and those who did, were largely engaged in their own private practice. Subsequently, the scheme was modified so that the salary of a contractual doctor was raised to the same level as a regular medical doctor, but without the additional public health responsibilities that the latter is burdened with. Moreover, in the modified scheme, the contractual doctor was not allowed any form of private practice.

Our investigation suggested that the contractual scheme mainly appealed to doctors who were already practicing in the same rural area. The possibility of continued private practice in the initial scheme was a significant attraction as the doctor could build credibility and a network of patients through the public health centre and return to full-time private practice once such contractual service had served these aims. The modified contractual scheme was of even less appeal to the local practitioners and only those who had been idle or with very few patients entered into contract. The doctor entered into contract for 11 months and this could then be extended on an annual basis.

Two years after the scheme was introduced, in late 2007, there were only 611 doctors on contract. Since September 2007, the UP High Court has issued a Stay Order that temporarily bans the contracting of doctors. The main opponents of the contractual doctors scheme were doctors who were waiting to join the government medical service on regular employment, since a contract did not give them access to promotions, pensions, job security and other benefits standard doctors enjoyed in the government medical service. Therefore it is from among those doctors most keen to join the government medical service that a few petitioned the High Court to ban the contractual scheme, which the Court upheld.

Tamil Nadu

In Tamil Nadu, the state government also favored *ad hoc* appointments of doctors (referred to in the State as recruitment through relaxation of rule on 10 (a)(1) basis)

since the regular process of recruitment through the State Public Service Commission is a lengthy one. For selection of doctors to join public service under a contractual appointment, the single appointing authority for all doctors in Tamil Nadu Government Service, the Directorate of Public Health and Preventive Medicine (DPH) informs the professional Employment Exchange in the state of the number of vacancies. The Employment Exchange is where doctors with both MBBS and Specialist training register their names for the possibility of future employment with the Government. The Employment Exchange maintains its own ‘seniority list’ based on the dates of registration in the Exchange and not on age or year of graduation from medical college. The Employment Exchange is expected to furnish five names for every vacancy the government declares, although in the case of Specialist posts there are very few registered in the first place with the Exchange. The DPH subsequently sends out “call letters” to the candidates to attend the process of Counselling (see Box 5 below) to work in rural or urban areas.

The doctors are appointed on contract with the understanding (an incentive) that their services shall be regularized. To be regularized, they need to appear for a “special qualifying examination” that the Tamil Nadu Public Services Commission (TNPSC) conducts (an additional incentive), in which the candidate on contractual appointment needs only to pass and not achieve a high grade relative to others to be selected, as is the case in the regular recruitment of doctors. There is, therefore, an incentive for doctors to join Government Service through initially a contractual appointment since there is effectively a lower benchmark set as the minimum requirement to be regularized for doctors already in contractual appointment compared to those attempting to join through a regular round of recruitment.

Almost all contractual doctors eligible for the “Special Qualifying Examination” that the TNPSC conducts happen to pass it (see Table 10 for 2003 exam). The government of Tamil Nadu, unlike the case in UP, has made significant use of the contractual system to recruit doctors into the Government Service. A significant incentive for doctors to aim to be regularized in Government Service, furthermore, is the greater likelihood of entering a post-graduate (PG) course of study in a medical college of the State (see Box 4 below).

Table 11: Numbers of doctors in Tamil Nadu recruited through Contractual Appointments in recent years

<i>Channel of Recruitment</i>	<i>Year</i>		
	2005	2006	2007
Contractual Appointment	1249	372	384
Regular Recruitment	-	1093	151

Box 4**Tamil Nadu: Recruiting doctors with the incentive of PG education**

In Tamil Nadu (TN), 50% of seats in each specialist branch of further study after a MBBS are reserved for in-service candidates, in addition to those in-service candidates selected in the 'open category'. Such practice significantly increases the prospect of candidates already in government service in entering a specialist or super-specialist course of study at government medical colleges, which are the majority of medical colleges in TN.

For the academic year 2008-09, the TN Government *exclusively reserved* for in-service candidates admission into certain specialist courses. These have been primarily Non-Clinical subjects (Pathology, Physiology, Bio-chemistry, Community Medicine, Anatomy) and those Clinical subjects (Radio Diagnosis, Anaesthesia) where the Government health care provision currently faces the most acute shortages. The Government also pays the in-service candidates the regular monthly stipend during the course of their studies, which are also used to cover tuition fees. To avail of this incentive to undertake PG education, the doctor must be in service for a minimum of 3 years and sign a bond with the Government. Interested in-service candidates for further education are compulsorily required to execute a bond for a significant sum (currently 10 lakh rupees for degree courses) as security amount with the undertaking that they will serve the TN Government till Superannuation or, in some specialist fields, 15 years. The table below records the numbers of doctors that enter government medical colleges in TN in recent years through this reservation policy.

Year	In-Service Candidate	Private Candidate	Total Selected	Percentage of in-service in total selected
2002	289	333	622	46.46
2003				
2004	296	438	734	40.33
2005	295	415	710	41.55
2006	314	316	630	49.84
2007	298	367	665	44.81
2008	271	344	615	44.06

Source: DME, Tamil Nadu Government

In addition, Tamil Nadu gives importance to 'experience' in drawing up the Merit List on which entry into a PG course of study in Government medical colleges is based. The entrance examination accounts for 90 marks of the total maximum of 100 that is attainable with 10 marks being exclusively reserved for 'experience' in specified rural or hilly areas. One mark is awarded for each completed year in a defined rural area for both in-service and non-service candidates to a maximum of Ten marks or ten years of such service. For service in hilly areas, 2 Marks are instead awarded at the completion of each year up to a maximum of 5 years of such service. The extent to which such an incentive works in drawing doctors keen on PG education to rural or hilly areas is yet to be evaluated.

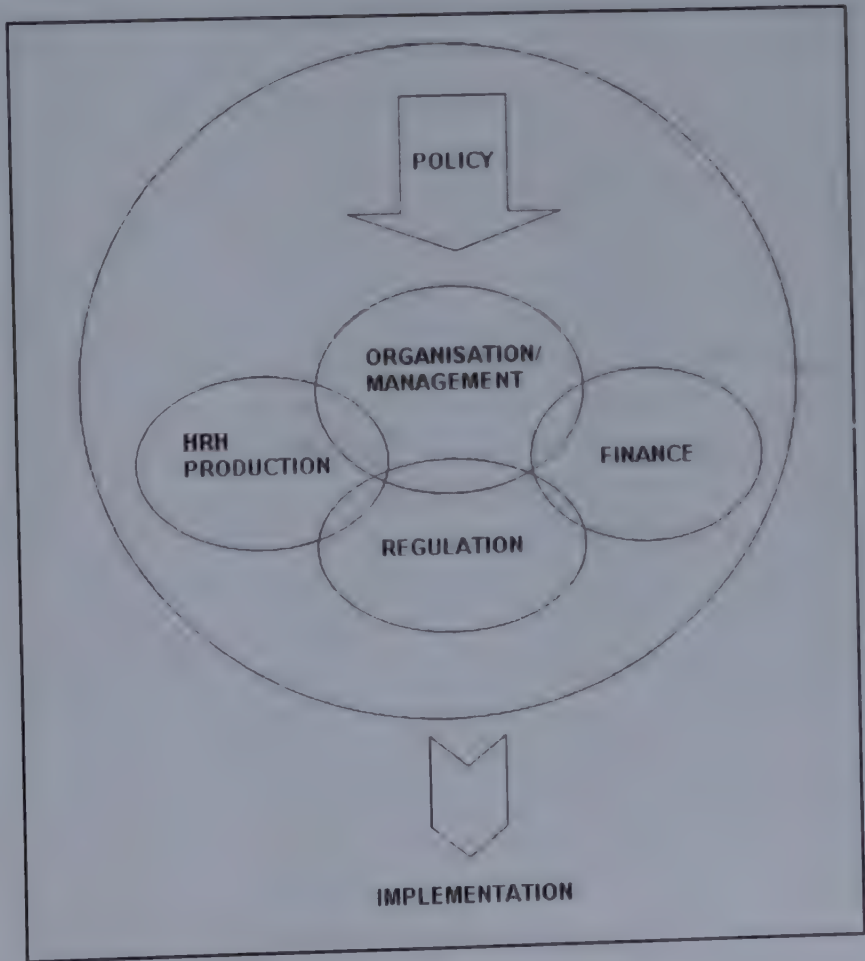
Part III

Case Studies of Institutional Factors Affecting the Implementation of HRH Policies

Using three case studies, Part III of this paper addresses the institutional problems relating to HRH that bureaucrats face in trying to implement programs and reforms. In each case, interest groups play an important role in determining the policies to address specific HR-related problems and the success or failure of these policies. As shown in the diagram below, the policy can then influence any of the core HRH functions of our conceptual framework and its implementation can have unintended or unforeseen implications.

The problems faced in the implementation of policy at the ground level contrast with those reviewed in Part I that policy is most often formulated around. This is principally because institutional weaknesses at state and local levels receive inadequate attention in the formal policy making process. Institutional inefficiencies or their near absence in some cases, such as in public health nursing in UP (Box 5), result in poorly implemented policies and failure to meet HR outcomes.

The three case studies address the key problem bureaucrats face, respectively, with regard to (i) the CHS cadre, (ii) the UP Provincial Medical Service cadre, and (iii) nursing in UP. We observe poor progress on HRH because grand strategies often cannot be implemented due to institutional weaknesses. Policy planners need to incorporate such institutional problems faced in their strategies and timelines.



Adapted from WHO Framework for HRH (2006)

Case Study 1:

CHS: Cadre organization weakens incentives possible for doctor recruitment and retention

The cadre management of the CHS is housed in the central Ministry of Health and Family Welfare, with the central Directorate – the principal technical/managerial support to health policy and national programs – almost entirely staffed by CHS doctors. Considering this proximity of the CHS to central health policy planning for better efficiency in the system and considering that the Centre has always had complete control (unlike the Centre's powers in the states, where it is only able to *promote* adopting best practices to state governments), it might well have been expected that the CHS cadre would have served as a model vastly superior in the implementation of its core HRH administrative management functions as compared to states such as UP. In fact, Departmental Promotion Committees (DPCs) that decide on promotions have been convened rarely for decades. The related agitation of CHS doctors and the doctors' lobby-group (JACSDO) for several years in the late-1980s resulted in the Tikku Committee Report (1990), and the central government accepted the doctors' call for time-bound promotions for the initial years of a CHS doctor's career (first 13 years for a GDMO; first 6 years for the specialist cadres). Even so, the absence of adequate promotions thereafter remains a severe grievance for the doctors.

Moreover, in spite of the CHS providing medical graduates employment with a Class 'A' central government service, very low numbers finally join as GDMO or in specialist posts after being successfully selected through the recruitment process (Tables 8 and 9, above). In addition, the attrition of experienced doctors employed with the CHS for several years is another significant problem that plagues the Service. A committee in 2005 headed by former health secretary, Javed Chaudhury, investigated and reported on the causes of this attrition of senior doctors from the Service. The Committee concluded that there had been an attrition of as much as 9.9% in the teaching and non-teaching specialist sub-cadres over the five years 2000-05 (GOI, 2006). The major wage differentials between the private sector and the public sector, with increased opportunities in the former may be one important change that makes the CHS less attractive to a fresh medical graduate than previously (Glinskaya and Lokshin, 2005). The migration of experienced doctors in the CHS to new opportunities in other countries or to the private sector may also explain attrition at higher levels in the Service. A third reason, however, is institutional and within the CHS: it stems from the subdivision of the CHS into four sub-cadres. This subdivision of the cadre has created a maze of bureaucratic problems that also affected promotions of in-service cadre doctors at the higher levels. The nature of this problem (outlined below) may appear of routine concern; however, it preoccupies officials and has led to the existing dissatisfaction of in-service CHS doctors.

Implications of the current organization of CHS on Attrition

The division of the CHS in 1982 into four sub-cadres introduced, over time, a structural problem affecting promotions and selection of in-service doctors to higher grade posts. Promotions have been within each of the four sub-cadres from entry-level up to and including the Senior Administrative Grade level (see diagram in Appendix: Figure 4). Thereafter, the sub-cadres are merged into a common hierarchy

for promotions to the Higher Administrative Grade posts of Additional Directors General of Health Service and equivalent and Director General Health Services. In the two Teaching Specialists and Non-Teaching Specialists sub-cadres, promotions up to the Senior Administrative Grade level are not only confined to within the particular sub-cadre, but also confined to within the respective Specialities and Super-Specialities. In the CHS itself there are over 70 separate seniority lists. Multiple seniority lists create their own share of problems, such as those of accountability and transparency in selections and postings to higher levels. The process of selection for promotion is however made further complicated since the sub-cadres and seniority lists need to be merged at the highest two levels of the CHS cadre. There is stagnation of large numbers of doctors at a single grade for many years, which is a central cause of complaint for CHS doctors over the last 15 years and more. It is a focal ground of conflict between CHS doctors and bureaucrats of the Cadre Controlling Authority at the Ministry that preoccupy both parties.

Implications of the current organization of CHS on Recruitment and career prospect incentives

Although the minimum qualification needed for joining the GDMO sub-cadre is a MBBS degree, there are a significant number of doctors with postgraduate (PG) degrees within the sub-cadre. Fresh PGs have in the past chosen to apply for entry-level positions in the GDMO sub-cadre for two reasons: (a) there are more job advertisements for the GDMO positions in the government than for the other three specialist sub-cadres every year; (b) more significantly, fresh postgraduate students find themselves ineligible for entry-level posts of the specialist sub-cadres as laid out in the CHS Service Rules after the sub-division into four sub-cadres. For entry-level posts in the Non-Teaching Specialist and Teaching Specialist sub-cadres, postgraduate degree holders are additionally required to have had a minimum work or teaching experience, respectively, of 3 years (this is 5 years for PG Diploma holders). However, fresh postgraduates interested in CHS for the possibility of a government job are far less keen *after 3/5 years'* experience upon completion of their postgraduate degree to apply for the entry-level pay scale of the specialist sub-cadres. The resulting paradox is that although there are postgraduate 'specialist' applicants for GDMO positions, there are few 'eligible' applicants to jobs at the entry-level of the specialist sub-cadres (see table 4).

Prior to the subdivision of the CHS cadre in 1982, MBBS and PG degree/diploma holders entered a unified cadre with a single seniority list. Entrants were regarded as 'Specialist' or 'General' depending on their educational qualifications and were posted to wherever vacancies appeared that best used their educational training and experience. The creation of sub-cadres forced recruitment to be rigidly to vacancies advertised within a particular sub-cadre and any future movement from the GDMO sub-cadre to the specialist sub-cadres was not permissible. Unlike before the subdivision of the cadre, doctors with postgraduate degrees, who join the CHS as a GDMO for reasons noted above, can no longer be recognized as specialists by the system. These post-graduate GDMOs are nevertheless undertaking functions of a specialist nature in various hospitals and teaching institutions. However, this institutional disregard of their specialist status means that they are unable to avail the advantages of career avenues and seniority lists open to the Specialist sub-cadre to which these PG-GDMOs cannot directly transfer to, even after valid experience within CHS. Participating institutions of the CHS currently have posts deemed

strictly as 'specialist sub-cadre' posts. The CHS is unable to recruit eligible candidates to fill vacancies in all the three specialist sub-cadres, and yet neither is it able to utilise the PG-GDMOs, already in its rolls with appropriate educational qualifications, to fill these vacant posts. Only due to the strict sub-division of the cadre, a PG-GDMO with the requisite experience gained in CHS and eligible for a specialist post vacancy is required to, remarkably, retake the Central Medical Services Examination and re-apply to the specialist sub-cadre post as a fresh applicant.

The problems of the CHS concerning low numbers joining the cadre and high rates of attrition of experienced doctors reflect the overall grievances of in-service doctors with the current cadre structure. The central Ministry of Health and its Cadre Controlling Authority overseeing the HR aspects of the CHS are, therefore, currently more occupied with the immediate internal concern of a Cadre Review to address the grievances of in-service doctors than any broader vision for the CHS to expand into an Indian Medical and Health Service, which continues to remain a proposal (Box 1). It is instructive that the root cause of these more immediate problems that the CHS cadre faces is the subdivision of the cadre. This was ostensibly an attempt by the Third Pay Commission to rationalize the cadre structure, but also, in effect, of greatest benefit to in-service specialist doctors. Two such Pay Commissions later, the Fifth Pay Commission ironically calls for the unification of the sub-cadres into a single cadre, reflecting now the grievance-demands of the majority GDMOs that comprise the collective action lobbying of CHS doctors.

Case Study 2:

UP Medical Service: How poorly planned cadre reforms created problems for new doctor recruitment

A rarity of promotions had also been a feature of the UP Provincial Medical Service (PMS) for decades and the constant lobbying of in-service doctors led to formulating new Service Rules in 2005, which brought about change in the structure of the cadre and several promotions to new positions with it. There had been few promotions previously due to institutional reasons of contested seniority lists, the absence of Annual Confidential Reviews (ACRs) and also a general apathy towards convening of the Departmental Promotion Committees that selected from among eligible candidates. The Provincial Medical Service Association had been outspoken about the doctors' grievances and involved with the government in the Cadre Review resulting in changes that most benefited in-service doctors.

The interests and demands of employees of the system on the officials create a situation where officials get preoccupied with these problems and sometimes come up with strategies to satisfy the employees which do not advance the health outcome mission of the organization. The new Service Rules and the formation of new sub-cadres have created fresh problems: the recruitment of new doctors and the way current in-service doctors have been repositioned has had consequences that have in fact been the very opposite of the goals that the national policy plans pursue.

The implementation of the new Service Rules created the following four sub-cadres on lines of generalist/specialist and gender: 1) Male General; 2) Male Specialist; 3) Female General; and 4) Female Specialist.

Unintended consequences of Cadre Reorganization

The promotional avenue for the Male Specialist sub-cadre has been made distinct from that of the Male General. The Male Specialist, in the revised rigid career paths, can become a Chief Medical Superintendent (CMS) at a hospital but not a Chief Medical Officer (CMO). The significance of this change lies in the fact that the post of the CMO is much sought after in the PMS since it is a post identified with control of power and patronage. As the CMO is the principal medical person in charge of a district, large financial resources are channelled through this person, both from the State and from Centrally Sponsored Schemes. When the cadres of Male General and Male Specialist were outlined in 2004, a deadline was stipulated to the existing in-service doctors to opt for the Specialist sub-cadre (and a non-response taken to be inclusion in the General sub-cadre). Their decision would be treated as final for the individual doctor's future career. With different seniority lists and promotional career paths charted out, when choice was given to the serving doctor to select between the two sub-cadres, the selection has been governed by where individual interests are served best. The UP Government discovered that as many as 1342 specialist doctors (with postgraduate training) had chosen or remained in the General cadre. This created an artificial scarcity for the Male Specialist sub-cadre and the functional absence of many specialists employed in the system from posts where their services were most needed and their particular trained skills utilised. Furthermore, the creation of multiple new seniority lists with the separation into sub-cadres has also created new

problems for officials, very reminiscent of the CHS experience. At higher-level positions, selection and promotion of in-service doctors is also based on a 'seniority' criterion. The need to satisfactorily 'merge' these several seniority lists for selection to higher grades now poses its own peculiar challenge to the officials in the Secretariat and the Directorate in UP.

New obstacles to efficient doctor recruitment resulting from Cadre Reorganization

The promotions of many doctors to the newly formed higher intermediate levels created 'space' for a round of new recruitment of Male General doctors at the entry-level in 2005. By the time the requisitioned posts in 2005 were filled in 2007, it was found that in relation to the officially sanctioned posts in the Service Rules, there appeared to be a 'surplus' number of some seven hundred doctors at the entry-level (Level 1) of the Male General sub-cadre (See Appendix: Table 1). The Directorate in Lucknow acknowledges that many of the 2278 doctors at the entry-level are not currently in the system. The process for determining a 'vacancy' when a doctor still remains on the registers is nevertheless lengthy, since the UP Public Services Commission needs to confirm that a doctor recruited by the Commission is no longer in active service. This need to formally declare a vacancy created additional work for the Directorate, with no link at all to its principal institutional function of providing technical assistance to health service delivery. At the institutional level of the directorate, there was consequently a problem that may be summed up in the following way: there was an undisputable need to recruit more doctors, but since the doctors who remained on the rolls exceeded the numbers sanctioned, no recruitment was possible.

The solution finally found for a second round of doctor recruitment was determined considering the social background of doctors. The Law requires that fixed percentage of the current workforce must be drawn from the Scheduled Castes (SC), Scheduled Tribes (ST) and Other Backward Classes (OBC) – that comprise the 'Reserved category'. The government refers to the gap between the numbers that are required to meet the percentages fixed for each of the 'Reserved categories' and the lower numbers actually present in the workforce as the 'Backlog'. The officials declared the 'Backlog' as vacancies in the health system that it could legitimately claim needed filled by Law. The UP Government of Chief Minister Mayawati in 2007 requisitioned a second round of recruitment of doctors to the entry-level, but restricted only to fill the 'Backlog'. Consequently, PMS jobs in this new recruitment round are open to those medical graduates who qualify on the basis of social background (SC, OBC and ST) and eligible for 'Reserved category' seats. All others are excluded. After the cadre reorganisation, there has been no recruitment of female doctors into posts deemed for the Female General sub-cadre, since numbers in the rolls were again more than sanctioned, creating an 'artificial surplus'. The options in the government medical service for female doctors with postgraduate specialisation has also been restricted to only certain specialist posts stipulated by the new Service Rules for the Female Specialist sub-cadre.

Demands for placement of in-service doctors may have negative consequences for better utilization of scarce skills and specializations. Moreover, in spite of proclaimed shortage of doctors in UP and in spite of falling numbers actually joining the PMS, the government health system effectively at present excludes whole sections from its limited supply of fresh medical graduates. Therefore, the policy of reorganization of

the cadre ostensibly aimed at institutional strengthening and better human resource management has had in fact the reverse effect, and its implementation weakened both. The cadre reorganisation was expected to reduce the number of legal cases that UP government officials are preoccupied with through large-scale promotions that were long overdue, but the restructuring has created its own host of problems and legal cases to concern officials as immediate problems. Although most of these legal cases are over minor struggles between individual doctors and the government, some conflicts are more serious. The UP High Court, acting on a petition of dissatisfied doctors, has ordered the UPPSC to halt the recruitment process for the current round of new doctors' posts to be filled and demanded the government explain how vacancies have been identified on the basis of the 'Backlog'. The government officials and the administrator-doctors in the Directorate, most of the latter being months away from retirement, remain overly distracted by these immediate problems than with broader issues of HRH planning in the health system.

Box 5 –Governance and accountability

The “Counselling” Process: Why conflict over promotions and transfers is relatively reduced in Tamil Nadu over UP

Tamil Nadu has adopted clear guidelines [G.O. (2D) No.131, 2007 revision] for the promotion and transfer of doctors and nurses. The system of Counselling attempts to bring a greater degree of transparency and information than the ad hoc basis of promotion and transfers currently dominant in UP.

The guideline on Counselling stipulates that every month-end, the details of vacancies, the cause of each vacancy and the date from which the vacancy arose should be displayed in the official website of the Health department. These list of vacancies, compiled and published every month, have to be then consolidated and published before the Counselling date. The final list is available for all to view before the dates of 7th April/7th May for the Counselling to be held in May/June respectively. The Rules for Transfers do not permit bureaucrats to make unilateral decisions of the transfer of doctors but instead involve the head of the institution at which the doctor is based and the doctor as 'applicant' for the transfer. Malpractice of transfers made on 'administrative grounds' is checked as the Rules stipulate that such transfers are only permissible after a detailed enquiry on the complaints are undertaken and the reason for transfer duly recorded, with all such transfers reported to the Government within a week.

Promotions to posts through Counselling are made in the order of seniority. The measure of 'seniority' is clearly demarcated for different posts and can be judged on the basis of any one of the following: service seniority, seniority on the Civil Medical List (initial list prepared on graduating marks obtained at MBBS) or 'station seniority' (calculated on actual period in the current post alone). As the Counselling progresses in the day, the vacancies available for promotions are erased depending on the 'choices' that candidates higher on the seniority list attending Counselling on that day make. Moreover, the outcome of the Counselling is determined and exhibited (except the cases where the Government is the transferring authority) on the day of the Counselling itself. To a large extent, therefore, bargaining for a change in the outcome of the Counselling is less possible with the results declared.

Since the system of Counselling prevailing at present is far more transparent in its process and in publishing information than the practice in UP, the actual process of transfers and promotions to posts (as different from their frequency) is comparatively far less a source of conflict in TN than UP. However, it is worth noting that even the system of Counselling gives no regard to performance incentives in matters of promotions and transfers; instead, it is entirely governed by the determination of 'seniority'.

Box 6 – Setting Numerical Targets is Not Enough (1)
Case: UP Medical Education and Scale of the Faculty Shortage problem

At the national level the Plans have been concerned with more medical colleges or not, with current policy of NRHM in favor of increased numbers. Especially in a populous state such as UP, while there are currently 16 medical colleges, population-based norms for the number of medical colleges (one college per lakh population) demand, at the very least, doubling (to 35) of the existing number. At the institutional level, however, is the severe problem faced even in the few medical colleges existing in the state of the enormous scale of faculty shortage. According to 2006 data, of the 738 officially sanctioned faculty positions in UP government medical colleges (and this is already lower than the numbers actually required), over 40 per cent of the teaching posts remained vacant (see Appendix: Table 3). This is a significantly higher proportion than the 20-25 per cent shortage suggested to exist in most departments of the country, with highs of 33 per cent. (Ananthakrishnan, 2007)

De-recognized PG courses

The implications of MCI Rules on faculty-student ratio for medical education has significantly contributed to the de-recognition of certain numbers of PG seats in UP medical colleges, even though the state government continues to admit students to fill these seats. MCI norms require a 1:1 ratio to be maintained between students and postgraduate teachers. This norm was created at a time and context far removed from the reality facing UP, but still must be adhered to in order for a medical college to retain MCI recognition. The annual numbers of additional faculty vacancies already increase each year due to the retirement or resignation of existing faculty – worsening an already acute problem. In this context, the MCI teacher-student norm only further exacerbates the problem of shortage. In UP, as elsewhere, this norm of 1:1 ratio between students and teachers has over time created excess seats in well-populated departments and increased shortage in departments where there is already faculty shortage. The norm results in a vicious cycle where as fewer numbers of faculty are present in these departments with shortage, few students can be admitted to pursue the PG speciality. It is then from the reduced numbers admitted to some of the key specialties for public health, that potential faculty can be drawn (including PSM – see table 3 in Appendix for details). The supply of faculty therefore does not match with the demand in a state like UP and this is, above all, the most pressing problem for officials in a health system, where there are few private medical colleges.

MCI Recognized and Un-recognized Post-Graduate Seats (2005)

	Total	GKP	JHS	KNP	LKO	MRT	AGR	ALLD
Recognized seats	466	0	16	113	131	62	86	58
Unrecognized seats	117	34	38	0	4	8	14	19
Total PG seats occupied	583	34	54	113	135	70	100	77

Note: GKP=Gorakhpur; JHS=Jhansi; KNP=Kanpur; LKO=Lucknow; MRT=Meerut; AGR=Agra; ALLD=Allahabad

Source: UP Government (dated 31 March 2005)

Case Study 3:

UP Nursing Service Rules: impact on educational incentives and institutions

After over a decade of neglect, the nursing profession features prominently in the strategy that current policy planning is engaged in to make better health care reach the poorest and most vulnerable. The specific strategy with regard to nursing is largely centred on the need and ways to produce more nurses. The state government in UP and officials overseeing nursing have a different problem to address first: there are few qualified and adequately trained nurse staff for teaching at the existing GNM schools which place these institutions precariously close to being, if not already, deemed unsuitable for producing nurses. If the government built new schools, they would face the same situation, since the problem is deeper and affects the entire government-nursing cadre of the state. The core problem is the government's own creation since it is the consequence of a change in nursing Service Rules in the state in 1996 to placate the agitation of nurses seeking a solution to facilitate promotions that were almost non-existent in the cadre.

The 1980 Service Rules for nurses give significance to educational qualification as an eligibility requirement for different nursing posts, as prescribed by INC norms. However, the State has never separately registered nurses with the following additional educational training: Public Health Nurse and B.Sc. (Nursing)/Post Basic B.Sc. (N). There is provision to only register nurses with ANM, GNM and LHV training. The absence of institutional records on qualified B.Sc and PHN nurses put them at a disadvantage, even as they should have been favored in promotions and with certain posts open only to them. In reality, like in the case of doctors, there were very few promotions of nurses in the 1980s and 1990s, which became a major source of grievance and conflict between nursing interest groups and the government. The principal nurses' union, the Rajkiya Nursing Sangh (RNS) had a significant role in pressuring the government to amend the Service Rules in 1996 and remove references to educational qualifications so that a large number of nurses who had served for decades could finally be promoted. The new Service Rules omitted any reference to educational qualifications (see comparison in Appendix: Table 4). Promotions are based on seniority in the service and the Annual Confidential Reports (ACRs). Since ACRs are poorly maintained, promotions are now effectively based entirely on grounds of number of years in the service. However, since there is no one single seniority list maintained, promotions have come to be viewed as ad hoc, politically influenced and are increasingly contested, even more so than before, with judicial activism on the rise.

Skewed incentives:

As long as an educational qualification or training beyond a GNM Diploma was considered relevant for the promotion of nurses, they were inclined to enter higher studies and the UP Government was also inclined to sending a fixed quota of nurses, on government expense, to undertake the two-year Post-Basic B.Sc. (Nursing) course and a ten-month Public Health Nursing Tutor course. However, once such educational preferences for promotions were waived, the nurses no longer had an incentive to undertake higher education, nor did the government find it necessary to send any persons from the nursing cadre for further education. Consequently, the lone Government College of Nursing offering a Post-Basic B.Sc.(N) degree to 25 students

has not a single candidate from UP State itself and is instead training candidates who have applied from other states.

In Tamil Nadu, such delinking of minimum required training for promotion to posts in nursing schools or colleges is impossible since the Service Rules specify such additional training or qualifications above that of a GNM Diploma to be essential. However, in UP, the promotion of nurses to teaching posts in nursing schools, without possessing the minimum prescribed educational training, has further jeopardised the quality of government nursing education institutions. The incentive for the nurses who successfully completed the 2-year course of Post-Basic B.Sc.(N) was that it made them eligible to become tutors in nursing schools and colleges as nursing tutors. Staff nurses who pursued a 10-month 'tutor course' in nursing, were eligible to become PHN tutors in nursing schools. With the change in Service Rules and subsequent promotions only on a seniority criterion, teaching staff in government nursing schools in UP no longer all have the educational training that the Indian Nursing Council (INC) deems mandatory (see Appendix: Tables 5 and 6). Consequently, the INC has withheld recognition from all nursing schools under the state government. This has created another dimension to the conflict between some nurses trained from these institutes and the government and friction between the State government and the central regulatory authority on the standards of the nursing institutes.

The government has ensured that the State Nursing Council, separate and autonomous from the INC, recognises these nursing schools and registers nurses graduating from these schools. Since it is the INC, and not the State Nursing Council that is tasked with the inspection of nursing schools, the latter recognises these government schools without undertaking inspection. There is consequently an overlapping regulatory role that both the INC and the State Nursing Council play in this case. Until and unless the state government pays 're-inspection fees' to the INC (and none have so far), no further inspection is undertaken. In data provided by the INC on request, none of the state government nursing schools has paid the re-inspection fees. In 2004, it was found that 61.2% of all nursing schools/colleges in the country were unsuitable for teaching (NCMH, 2005). De-recognition by the INC has little effect. The result is the production of nurses and midwives with inadequate skills, who later work in an environment of ineffective regulation. This case study on nursing in UP, therefore, confirms the diagnosis of the NCMH Background paper on HRH that 'the INC does not have effective control over the nursing services'.

In this context of a weak regulatory environment and inadequate educational institutions to provide minimum training for any teaching staff in nursing schools, there has in fact been a multifold increase in the number of new private nursing schools over a short period (see Appendix: Figure 3). In identifying the common reasons for the failure of INC recognition to nursing schools, the President of the INC begins the list with there being inadequate number of nurse teachers and nurse teacher specialists and non-adherence to the Council's norm for teacher to student ratio (Background NCMH paper on Nursing). In UP, new admissions to government nursing schools over the last ten years have not been an annual feature (as previously), but once in three years on average. Consequently a new batch is admitted only as the previous batch graduates with a GNM diploma, but the size of the batch has been much larger than at the time of annual admissions – violating the INC norm of teacher to student ratio. The admission process to private nursing schools is left to the

institution itself and therefore there is no check on the charges levied by these schools to admit new students or on the minimum education the INC prescribes for admission to a GNM course.

Therefore, looking simply at annual numbers of nursing schools and numbers of graduating 'qualified' staff nurses, the trend appears to be very positive. Lack of attention to faculty and training capacity nevertheless will result in failed targets and poor quality nurses. The problems faced in policy implementation, as highlighted through this case in UP, may even question the very soundness of more numbers of nursing schools and nurses while the present institutional inadequacies continue to allow for poor teaching staff and a weak regulatory system. .

Box 7 – Setting Numerical Targets is Not Enough (2)**Case: De-institutionalization of Public Health Nursing Education in UP**

NRHM plans for 2 ANMs in every sub-centre and has allocated funds also for an increase in the number of sub-centres. UP currently has 20,251 sub-centres, and official documents state that each is manned by a single ANM. Under NRHM, the state envisages 7,000 additional sub-centres. The NRHM plan of 2 ANMs in the existing and new sub-centres, therefore, calls for the additional training of broadly 34,000 new ANMs in the span of five years remaining of the Mission. This ambitious aim depends on institutions with teaching staff for the production of ANMs, but the condition in public health nursing has become even worse than the deterioration in educational institutions for clinical nursing; they simply ceased to exist. Through a policy decision, all the 40 ANM Training Centres and 4 health schools, which were producing ANMs, LHVs, PHNs and PHN Tutors were closed down in 1992. The reason was that the number of ANMs required trained for each sub-centre had been achieved. At a time of financial difficulty, the step appeared justified, even though it affected the training of community-oriented nurses other than ANMs. The feeder system of education to LHV, PHN, PHN Tutor and higher posts in the public health nursing ended simultaneously with the decision that more trained ANMs were not required in the government health system. By the time a new Multipurpose Worker Act became operational in 1997, there were no health schools functional and there was consequently no institutional structure for the training of LHVs or training for posts of PHN and PHN Tutor. This resulted in the numbers of Public Health Nurses (PHN) and PHN Tutors significantly depleting. Since the health schools were closed, the numbers of LHV/Health Supervisor (female) also significantly diminished. A previous policy decision of the state government, therefore, directly led to a shortage crisis of teachers and trained supervisors in public health nursing.

Institutional delay on the part of government in framing Service Rules for the public health nursing stream has also contributed significantly to the current crisis. The personnel department of the UP Government made it mandatory in 1990 that promotions could only be officially sanctioned if there were Service Rules in place for every cadre where such promotions were overdue. The Service Rules for public health nursing, in the eighteen years that have elapsed since then, remain absent. With no promotional avenues and no educational avenues, there appeared to be no options at all for those who were already LHVs, PHNs, or PHN Tutors. Currently, only very few PHN and PHN Tutors therefore still remain in service and border on official retirement age. The challenge to revive the health schools, training centres and to ensure community health teaching for the GNM Schools is now made increasingly more difficult due to dearth of trained teachers, let alone fulfilling the aim of NRHM to increase the capacity and numbers of such schools. It is significant to note that in Tamil Nadu, there exists detailed Service Rules for all sections of nursing, including all posts in Public Health Nursing.

Part IV

Discussion

HRH has been an important area of health policy planning at the national level over the years. Part I of this paper undertakes a historical review of policy priorities across Five-Year Plans and of reports influencing the policy agenda concerning HRH. This review reveals that the principal items on this policy agenda are not that numerous. Moreover, many of these HRH policy issues prioritized over time remain the same, such as the formal integration of AYUSH practitioners with the public sector health system or the training of paramedical human resources. It is the implementation of many of these policies in the states that has been unsatisfactory and perhaps one reason why they have remained policy goals still to be achieved in subsequent plan periods.

Through three cases, this paper further probes the process of a key HRH issue such as recruitment of doctors and the different institutional contexts in which policy is implemented. The evidence from the cases suggest that in the implementation of policy, the states (including the central ministry for the CHS) face more immediate institutional problems that have so far received largely insufficient attention in the national policy and plans. The context-specific nature of the institutional problems faced at the state and local levels of implementation may partly explain the inability of policy-planning at the national level to adequately recognize the role they play.

Examples from this paper may suffice to make the point that while increasing numbers is a legitimate focus of policies at the national level, institutional weaknesses plague their successful implementation. Policy at the national level, for instance, has focused on strategies to increase the numbers of doctors joining the government medical service. At the implementation level in UP, however, the immediate problems due to cadre reorganization made the government implement a policy that restricted participation in the latest recruitment drive to only medical graduates from the 'reserved category'.

Similarly, with regard to medical education, recent policy planning has been largely to increase numbers of medical colleges through greater financial allocations and the relaxation of rules in establishing new medical colleges. In UP, even the few existing medical colleges face a more severe immediate problem of faculty shortage. The implementation of a policy of increasing numbers of medical colleges is less likely to be effective without adequate measures addressing the institutional context required to foster and attract faculty.

At the national level, policy priority is understandably on more nursing schools to address the acute shortage of nurses in the country. In UP, the current Service Rules for nurses allows for nurses not qualified or trained for teaching posts to occupy these, violating mandatory INC requirements. More nursing schools without adequate institutional strengthening and changes in Service Rules will not allow these schools to meet the minimum quality standards that the INC prescribes. Current policy at the national level, likewise, targets two ANMs per sub-centre. The de-institutionalization of public health nursing in UP, as in many other states, makes the implementation of such policy difficult as there is a lack of ANM trainers. Increasing the numbers of

ANM trainers, on the other hand, requires better service conditions to attract back to the system those still trained and increased institutional capacity to educate sufficient new numbers of them.

The evidence also suggests that with the challenges of implementation context-specific, a priority concern of HRH in UP may either never have been a problem in another state such as Tamil Nadu or of much less significance. The little regard for institutional realities in formal policy making can indeed be seen as a symptom of the very problem of weak institutions. There is a disconnect, in effect, between the formalism of policy making and actual implementation. Policies in the past have tended to underestimate the role of weak institutions. Subsequently, institutional “inefficiencies” have resulted in poorly implemented policies and HR results. During the policy making process, the inadequate attention to the institutional context that influences implementation needs to be acknowledged as a weakness in the system and explored more fully than has been possible in this paper.

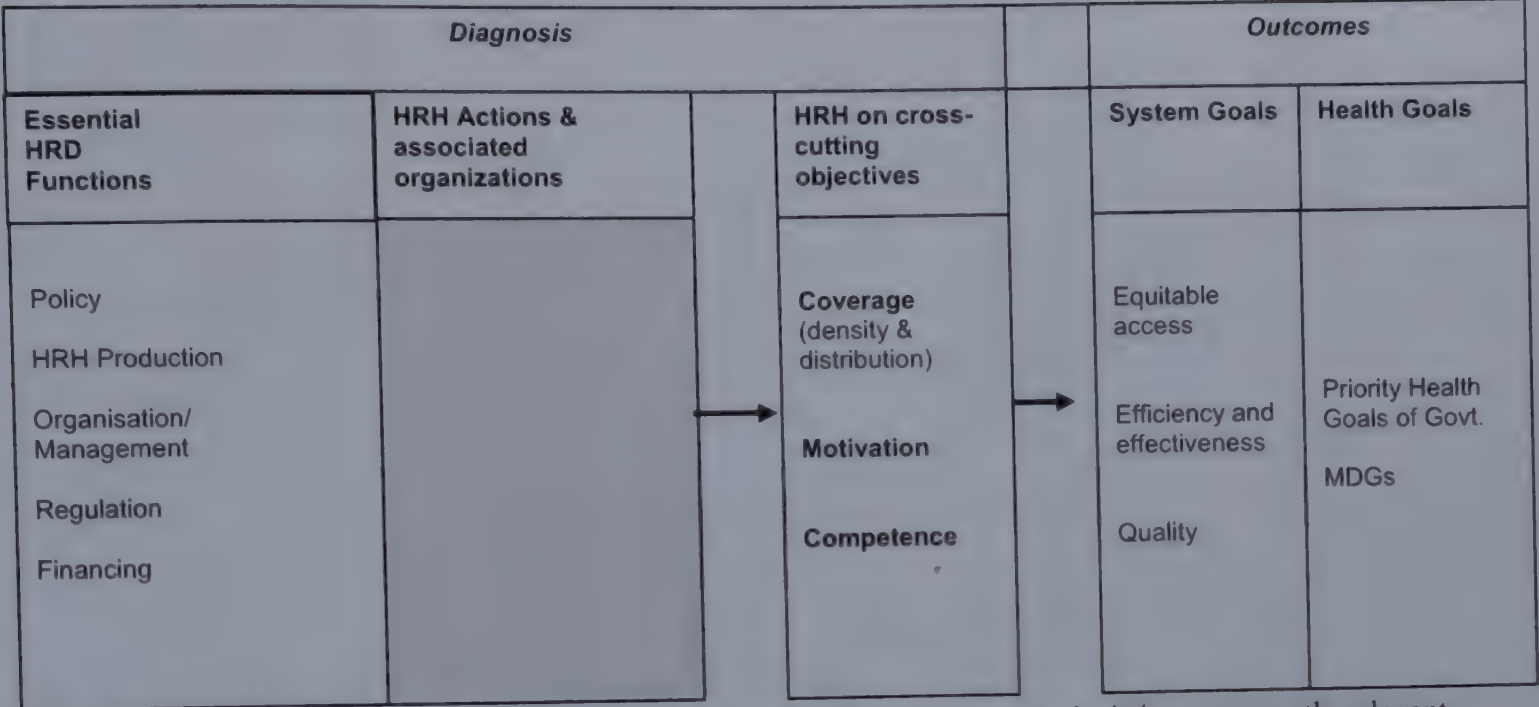
From the evidence in the cases, it emerges that the self-interest and rentseeking of stakeholders have important influence that policy and institutions have less successfully managed or channeled into support for public goals. A more explicit acknowledgement of and strategically planned engagement with stakeholders requires acceptance of a reality different from policy as solely the purview of motivated/altruistic bureaucrats in the formal unitary model of the civil service. Evidence from this paper suggests there are sufficient grounds for a detailed understanding of stakeholder interests and influence when formulating policy. Such strategic appraisals of stakeholder interests and influence also need to be context-specific. For instance, the doctors’ association in the CHS has opposed the organization of sub-cadres where as the support of the government doctors’ association in UP was needed for the re-organization of the cadre to new sub-cadres.

The commitment of significantly greater financial resources that the central government intends to channel into the health sector, the renewed focus of NRHM on the HRH aspects of health policy and the greater role of the states expected in planning a state-specific health policy potentially provides an opportunity to productively further a focus on institutions and the implementation process. The NRHM framework is designed to provide states with a greater role in policy planning through the instrument of detailed State PIPs for the health sector. There is now new opportunity to review the HRH plans of these State PIPs in select states and to assess to what extent they reflect the particular problems of implementation and institutional inadequacies separately diagnosed for those states. The importance of the linkage of institutional analysis in the states for a realistic assessment of State PIPs may be a task relevant specifically to the new National Health Systems Resource Centre (NHSRC).

Two conclusions may be drawn from the diagnosis substantiated in this paper. First, there is a need to address weak institutional processes and design policies to reflect more realistic assessments of what institutions can deliver in context of different states. Second, there is a need to systematically map stakeholder interests and influence in specific HRH issue and location contexts to strategically manage their power for better implementation of policy formulated. NRHM provides a favorable environment to further both of these measures and an opportunity to accrue real benefit from them for more efficient implementation of policy.

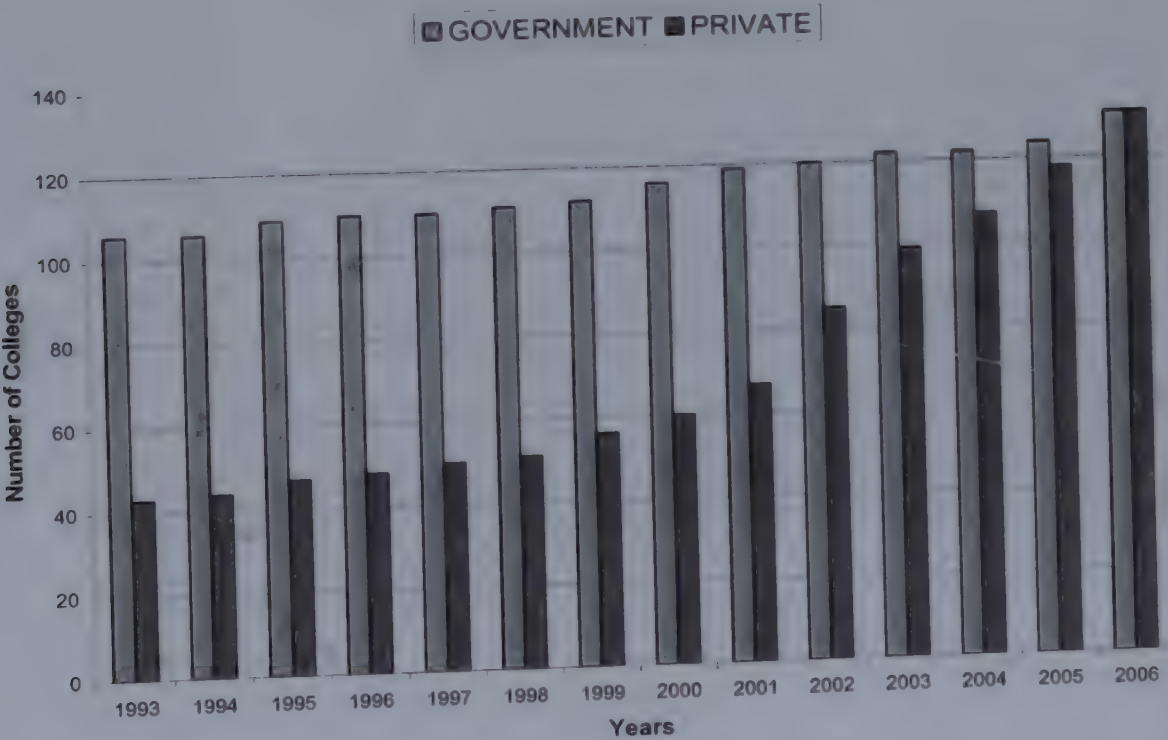
APPENDIX

Figure 1: Essential HRH Functions framework and Health Outcomes



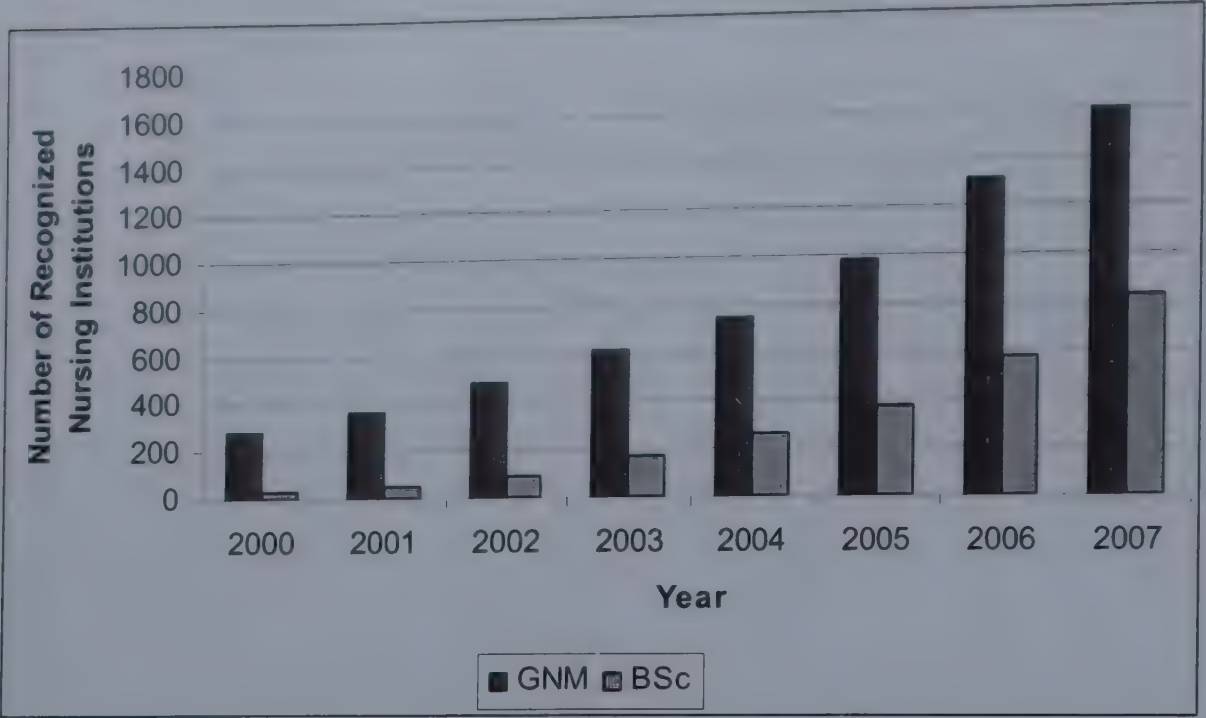
NB: The grey area above denotes where institutions fit and why institutional analysis is consequently relevant.
Adapted from JLI Framework (2004)

Figure 2: Growth of Medical Colleges in recent years (Public and Private)



Source: MCI

Figure 3: Growth in Recognized Nursing Institutions (2000-2007)



Source: INC

Table 1: PMHS Male Cadre Strength in Oct-Nov 2007 (and as on 1 May 2007)

MALE									
Specialist				General					
I	II	III	IV	V	VI	VII	VIII	IX	
				Change (working status)				Change (working status)	
	Sanctioned	Working	Vacant		Sanctioned	Working	Vacant		
L-1	1372* (1080)	802 (792)	570 (288)	10	1590* (1547)	2278 (2278)	- 688 (-731)	0	
L-2	978* (938)	730 (739)	248 (199)	-9	1518 (1518)	1007 (1007)	511 (511)	0	
L-3	900 (900)	847 (864)	53 (36)	-17	1432 (1432)	834 (834)	598 (598)	0	
L-4	884* (883)	610 (670)	274 (213)	-60	1293 (1293)	741 (741)	552 (552)	0	
L-5	40 (40)	23 (24)	17 (16)	-1	50 (50)	12 (14)	38 (36)	-2	
Total	4174 (3841)	3012 (3089)	1162 (752)	-77	5883 (5840)	4872 (4874)	1011 (966)	-2	

Source: Directorate of Medical Health, Lucknow, U.P.

**NB: Key for L1 to L5 positions to be added.

Table 2: PMHS Female Cadre Strength in Oct-Nov 2007 (and as on 1 May 2007)

FEMALE									
Specialist									
I	II	III	IV	V	VI	VII	VIII	IX	
	Sanctioned	Working	Vacant	Change (working status)	Sanctioned	Working	Vacant	Change (working status)	
L-1	393* (320)	90 (157)	303 (163)	24	150 (150)	453 (453)	-303 (-303)	0	
L-2	301* (300)	132 (41)	169 (259)	(91)	138 (138)	28 (28)	110 (110)	0	
L-3	270 (270)	226 (232)	44 (38)	-6	127 (127)	71 (71)	56 (56)	0	
L-4	250 (250)	186 (190)	64 (60)	-4	119 (119)	122 (122)	-3 (-3)	0	
L-5	9 (9)	5 (7)	4 (2)	-2	5 (5)	2 (2)	3 (3)	0	
Total	1223 (1149)	639 (627)	584 (522)	12	539 (539)	676 (676)	-137 (-137)	0	

Source: Directorate of Medical Health, Lucknow, U.P.

Table 3: Current Situation of Medical Faculty in UP State (2006)

S.No.	Name of Discipline	Sanctioned	Currently-filled	Vacant
1.	Anatomy	36	14	22
2.	Anesthesia	49	37	12
3.	Biochemistry	17	09	08
4.	Cardiology	17	08	09
5.	Dentistry	13	09	04
6.	E.N.T.	18	10	08
7.	Forensic Medicine	15	06	09
8.	General Medicine	51	24	27
9.	Neurology	08	06	02
10.	Nephrology	07	04	03
11.	Human Metabolism	03	01	02
12.	Nuclear Medicine	01	-	01
13.	Gastroenterology	04	02	02
14.	Microbiology	11	05	06
15.	O & G	44	33	11
16.	Health Education	06	01	05
17.	Ophthalmology	29	22	07
18.	Orthopedics	26	13	13
19.	Pediatrics	31	25	06
20.	Pathology	40	28	12
21.	Pharmacology	34	17	17
22.	Pharmacy	19	12	07
23.	Physiology	37	18	19
24.	Psychiatry	08	05	03
25.	Radio-diagnosis	17	09	08
26.	Radio-therapy	15	09	06
27.	S.P.M.	47	31	16
28.	Statistician	06	03	03
29.	Assistant Public Health Engineer-cum-Lecturer	01	-	01
30.	Skin and BD	14	08	06
31.	General Surgery	50	34	16
32.	Urology	02	02	-
33.	Thoracic Surgery	05	02	03
34.	Neuro-surgery	12	06	06
35.	Plastic Surgery	06	04	02
36.	T.B.	18	07	11
37.	Demography	06	05	01
38.	Cardiac Anesthesia	04	-	04
39.	Physicist	08	05	03
40.	Cardiac Surgery	03	02	01
		738	436	302

Source: Directorate of Medical Education, U.P. Government, Lucknow

Table 4: Changes in Service Rules (Gazetted) - Source: Service Rules for Nursing, 1980 and 1996; Current posts existing

1980 Post	Name of 1980 (Source of Recruitment)	1996 (Source of Recruitment)	Current Post
Tutor (Education)	Promotion from amongst permanent Sisters and ward Masters with at least 3 years' service as such and who possess diploma in nursing administration or Nursing Tutor's Diploma or B.Sc. Nursing (Post Basic)	Promotion from amongst substantively appointed Sisters and ward Masters who have completed 7 years' service, as such on the first day of recruitment	Tutor
Assistant Matron (Service)	Promotion from amongst permanent Sisters who have put in at least 3 years' service as such and who possess diploma in nursing administration or Nursing Tutor's Diploma or B.Sc. Nursing (Post Basic)	(Existed in 1996 Rules, but no longer applicable, as position currently merged with that of Matron)	(position merged with that of Matron)
Principal Tutor (Education)	Promotion from amongst permanent Tutors and assistant Matrons who have put in at least 3 years' service as such and who possess diploma in nursing administration or Nursing Tutor's Diploma or B.Sc. Nursing (Post Basic)	Promotion from amongst substantively appointed Tutors and PHN Tutors who have completed 5 years' service, as such on the first day of recruitment	Principal Tutor
Matron	Promotion from amongst permanent Assistant Matrons, Female Tutors, Female Theatre Supervisors and PHN Tutors who have put in at least 3 years' service as such and who possess diploma in nursing administration or Nursing Tutor's Diploma or B.Sc. Nursing (Post Basic)		Matron (including previous positions of Assistant matron and Deputy Superitendent, Nursing Services)
Senior Matron	Promotion from amongst permanent Matrons who have put in at least 3 years' service. Other things being equal, preference shall be given to persons possessing diploma in nursing administration or Nursing Tutor's Diploma or B.Sc. Nursing (Post Basic)	Promotion from amongst substantively appointed Matrons who have completed 3 years' service, as such on the first day of recruitment	Senior Matron
Assistant Superitendent, Nursing Services	Promotion from amongst permanent Senior Matrons, permanent Matrons, permanent Principal Tutor (Female) who have put in at least 3 years' service		(position merged with that of Deputy Superitendent, Nursing Services)
Deputy Superitendent, Nursing Services	Promotion from amongst permanent Assistant Superitendent, Nursing Service and permanent Senior Matrons		(two positions existing before merged to a single post) Assistant Director (Nursing)
Deputy Director, Medical and Health Services (Nursing)			Post renamed at equivalent level as Joint Director (Nursing)

Table 5: Norms for Schools of Nursing (GNM) with 60 students (i.e. annual intake of 20 students)

Teaching Faculty	Previous Norm	Current Norm till 2012 (after relaxation)
Principal	1	1
Vice Principal	1	1
Senior Tutor	1	0
Tutor	5	4
Additional Tutor for Interns	1	1

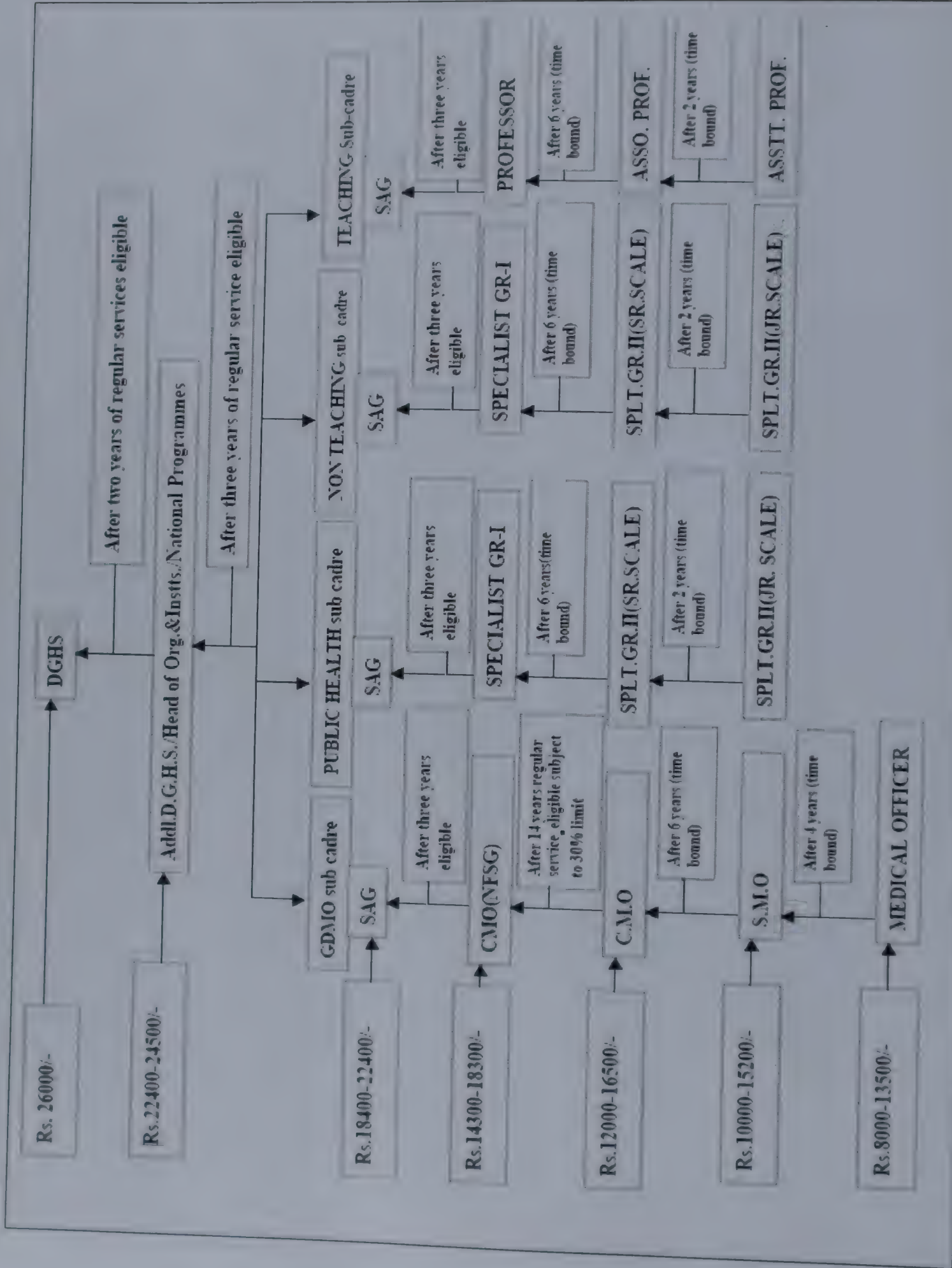
Source: Indian Nursing Council, New Delhi

Table 6: INC Norms for Qualification of Teaching Staff (Nursing Schools for GNM Diploma)

Post	Educational Qualification Norm (Previous)	Current Educational Qualification norm till 2012 (after relaxation)
1. Principal	M.Sc. Nursing with 6 years of teaching experience or B.Sc. Nursing (Basic)/Post-Basic with 8 years of teaching experience.	M.Sc. Nursing with 3 years of teaching experience or B.Sc. Nursing (Basic)/Post-Basic with 5 years of teaching experience
2. Vice Principal	M.Sc. Nursing with 4 years of teaching experience or B.Sc. Nursing (Basic)/Post-Basic with 6 years of teaching experience.	M.Sc. Nursing or B.Sc. Nursing (Basic)/Post-Basic with 3 years of teaching experience.
3. Senior Tutor	M.Sc. Nursing with 2 years of teaching experience or B.Sc. with 4 years of teaching experience	
4. Tutor	Minimum requirement of Diploma in Nursing Education and Administration with 2 years of professional experience	Minimum requirement of Diploma in Nursing Education and Administration with 2 years of professional experience

Source: Indian Nursing Council, New Delhi

Figure 4: Career Paths and Compensation Levels of the Central Health Scheme sub-cadres (source: MOHFW)



Select Bibliography

- Abraham, L. 2005. Indian Systems of Medicine (ISM) and Public Health Care in India. In *Review of Health Care in India*, edited by CEHAT. Mumbai.
- Amrith, S. 2007. The Political Culture of Public Health in India: A Historical Perspective. *Economic and Political Weekly* (13 January).
- Ananthakrishnan, N. 2007. Acute shortage of teachers in medical colleges. *The National Medical Journal of India* 20 (1):25-29.
- Bajaj Committee, GOI. 1987. Report of Expert Committee on Health Manpower Planning, Production and Management: Government of India.
- Berman, P. 1987. Community-Based Health Workers: Head Start or False Start towards Health for All? *Social Science and Medicine* 25 (5):443-459.
- . 1998. Rethinking Health Care Systems: Private Health Care Provision in India. *World Development* 26 (8):1463-1479.
- Berman, P., and R. Ahuja. 2008 unpublished. Government Health Spending in India: Getting to 2% of GDP.
- Bhore Report, GOI. 1946. Report of the Health Survey and Development Committee. New Delhi: Government of India.
- Bossert, T., et. al. 1998. Transformations of ministries of health in the era of health reform: the case of Columbia. *Health Policy and Planning* 13 (1): 59-77.
- CEHAT. 2005. *Review of Health Care in India*. Mumbai.
- Central Bureau of Health Intelligence, GOI. 2005. *Health Information of India 2005*. Delhi: Government of India Press.
- Chaudhury, N., et al. Missing in Action: Teacher and Health Worker Absence in Developing Countries. *Journal of Economic Perspectives* 20 (1): 91-116.
- CPR. 1999. Report on the Restructuring the Ministry of Health & Family Welfare. New Delhi: Centre for Policy Research.
- DFID. 2003. Promoting Institutional & Organisational Development. London: Department for International Development.
- Dreze, J., and A. Sen. 2002. *India: Development and Participation*. Oxford: OUP.
- Duggal, R. 2005. Historical Review of Health Policy Making. In *Review of Health Care in India*, edited by CEHAT. Mumbai.
- Finance Commission, GOI. 2004. *Report of the Twelfth Finance Commission (2005-10)*. New Delhi: Government of India.
- Glassman, A., M. Reich, K. Laserson, and F. Rojas. 1999. Political analysis of health reform in the Dominican Republic. *Health Policy and Planning* 14 (2):115-126.
- Glinskaya, E., and M. Lokshin. 2005. Wage Differentials between the Public and Private

Sectors in India. *World Bank Policy Research Paper* (3574).

- GOI. 1989. National Education Policy in Health Sciences (Draft): Consultative Group Report submitted by Prof. J.S. Bajaj.
- . 1989. Report of the High Power Committee on Nursing and Nursing Profession: Ministry of Health & Family Welfare.
- . 1990. Report of the High Power Committee on Career Improvement and Cadre Restructure of Central Health Service: Ministry of Health & Family Welfare.
- . 2006. Retention of Health Manpower in Government Sector (CHS): Report of the Expert Committee.
- GOI, NRHM. 2005. *National Rural Health Mission: Framework of Implementation (2005-2012)*. New Delhi: Government of India.
- . 2008. Common Review Mission. New Delhi: Ministry of Health & Family Welfare.
- Haggard, S., and S. Webb. 1993. What do we know about the political economy of economic reform? *The World Bank Research Observer* 8 (2):143-68.
- Hariharan, S. 2004 unpublished. Central Health Service - A Review for Government.
- Herbst, J. 1990. The structural adjustment of politics in Africa. *World Development* 18 (7):949-958.
- Hirschman, A.O. 1970. *Exit, Voice and Loyalty*. Cambridge, Massachusetts: Harvard.
- ICSSR/ICMR. 1981. *Health for All: An Alternative Strategy*. Second Edition, 2002 ed: ICSSR.
- Illich, I. 1975. *Medical Nemesis: the expropriation of health*. London: Calder & Boyars.
- Jeffrey, R. 1986. Health Planning in India 1951-84: the role of the Planning Commission. *Health Policy and Planning* 1 (2):127-137.
- . 1988. *The Politics of Health in India*. Berkeley: University of California Press.
- JLI. 2004. Human Resources for Health: Overcoming the crisis: Joint Learning Initiative (Global Equity Initiative, Harvard University).
- Leslie, C. 1985. What Caused India's Massive Community Health Worker Scheme. *Social Science and Medicine* 21 (8):923-930.
- Mahal, A., and M. Mohanan. 2006 unpublished. Medical Education in India and its implications for access to care and quality.
- Martinez, J., and T. Martineau. 1998. Rethinking human resources: an agenda for the millenium. *Health Policy and Planning* 13 (4):345-358.
- Mavlankar, D. Undated mimeo. Auxiliary Nurse Midwife's changing role in India.
- Misra, R., R. Chatterjee, and K. Sujatha Rao. 2003. *India Health Report*. Delhi: OUP.

- NCMH, GOI. 2005. *Background Papers: Financing and Delivery of Health Care Services in India*. New Delhi: Government of India.
- . 2005. *Report of the National Commission on the Macroeconomics of Health*. New Delhi: Government of India.
- NHSRC. 2008. State Public Health Budget: National Health Systems Resource Centre.
- Nursing, (Report). 2005. Situational Analysis of Public Health Nursing Personnel in India. Hyderabad: Academy for Nursing.
- Olson, M. 1982. *The Rise and Decline of Nations*. New Haven: Yale University Press.
- Planning Commission, GOI. Five Year Plans (various years).
- Peters, D., K. Sujatha Rao, and R. Fryatt. 2003. Lumping and splitting: the health policy agenda in India. *Health Policy and Planning* 18 (3):249-260.
- Rao, M. Govinda, and N. Singh. 2005. *Political Economy of Federalism in India*. New Delhi: OUP.
- Reich, M. 2002. The politics of reforming health policies. *IUHPE - Promotion & Education* 11 (4):138-142.
- . 1994. Bangladesh Pharmaceutical Policy and Politics. *Health Policy and Planning* 9 (2): 130-43
- Roberts, M., W. Hsiao, P. Berman, and M. Reich. 2004. *Getting Health Reform Right*. Oxford: OUP.
- Rohde, J., and H. Vishwanathan. 1995. *The Rural Private Practitioner*. Oxford: OUP.
- Shiffman, J., and R.R. Ved. 2007. The state of political priority for safe motherhood in India. *BJOG* 114:785-790.
- Shrivastava Committee, GOI. 1975. Report of the Group on Medical Education and Support Manpower: Government of India.
- Skocpol, T. 1995. The Rise and Resounding Demise of the Clinton Plan. *Health Affairs* Spring:66-85.
- Sundararaman, T. 2008. *Human Resources for Health: Initiatives under the National Rural Health Mission*. Powerpoint presentation at NIHFW-WBI Flagship Course.
- UP, Government of. 1980. The Uttar Pradesh Nursing (Gazetted) Service Rules: GoUP.
- . 1996. Nursing Service Rules (Gazetted): GoUP.
- Walt, G. 1994. *Health Policy: An Introduction to Process and Power*. London: Zed Books.
- WHO. 2006. *Tools for Planning and Developing Human Resources for HIV/AIDS and other health services*. Cambridge, MA: Management for Health.
- . 2007. Not Enough Here. Too Many There.: Health Workforce in India. New Delhi: World Health Organization.
- World Bank, WDR. 2004. *Making Services Work for Poor People*. Washington, D.C.: World

Bank.

———. 2007. *Tools for Institutional, Political and Social Analysis of Reform*. Washington, DC: The World Bank.

